



The Modern Hospital

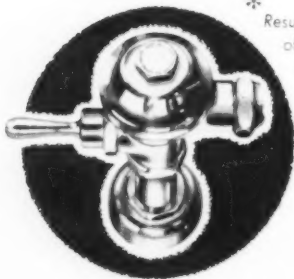
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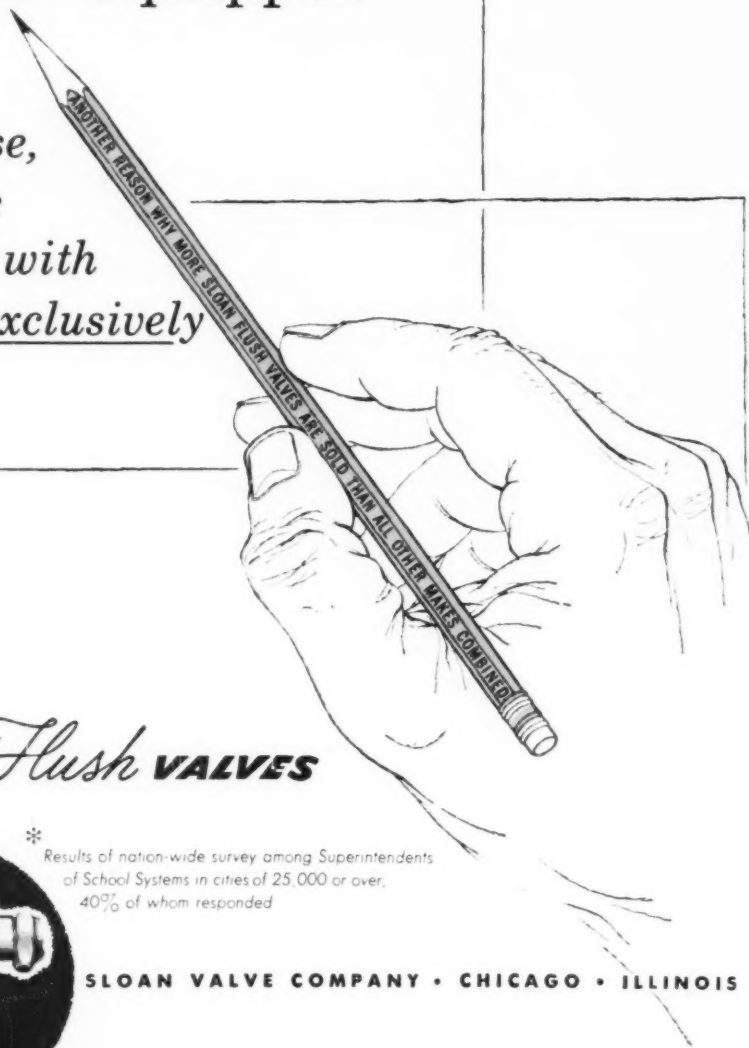
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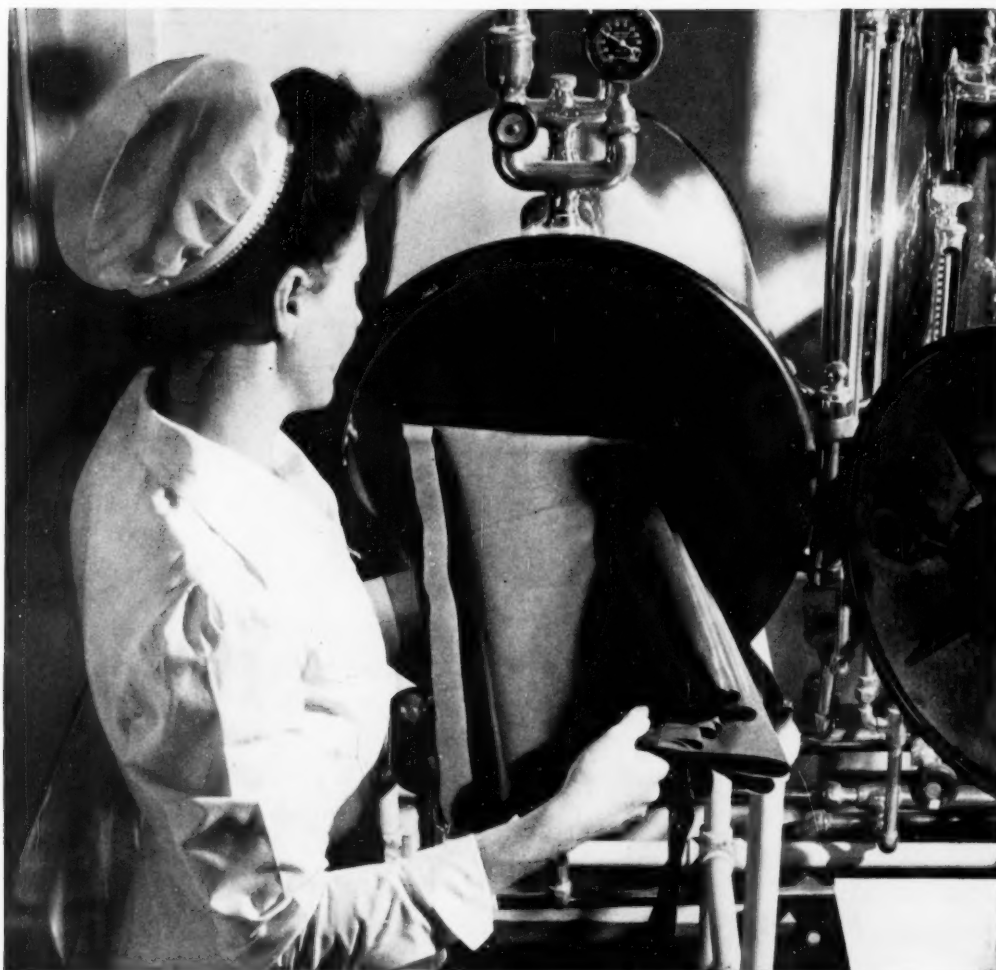
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AMONG THE AUTHORS

John K. M. Pryke, whose article about radiant heating for hospitals appears on page 72 of this issue, is a partner of the New York firm of Slocum and Fuller, consulting engineers. He has designed radiant heating installations for a number of large buildings, including department stores, hospitals and apartment hotels. Mr. Pryke started working with radiant heating developments twenty years ago, when he was an apprentice in the office of Richard Crittall and Coy, heating and ventilating contractors, in London, England. As he worked his way up in the firm, becoming a draughtsman and, later, engineer, he attended evening classes at the polytechnic institute, London University, where he received his B.Sc. in engineering in 1935. Two years later, he was awarded a fellowship for study of heating and air conditioning work in the United States; he was here for more than a year, traveling all over the country and inspecting scores of major installations in buildings of all types.

Mr. Pryke returned to England as technical director of an air conditioning company. He was commissioned lieutenant in the Royal Electrical and Mechanical Engineers when the war started, went into action with his unit, and was taken prisoner. As a prisoner of war, he spent his spare time designing the complete engineering services for a modern manufacturing plant. After the war, Mr. Pryke came to this country as a consulting engineer.

Elsie T. Berdan is associate chief of the nursing section, Division of Hospitals, Public Health Service, a position she was appointed to following her wartime service as consultant in nursing education for the Cadet Nurse Corps. Miss Berdan is a graduate of St. Mary's Hospital School of Nursing, Minneapolis. She did graduate work at the Catholic University, Washington, D.C., and has an M.S. in nursing education. Her teaching and executive experience in nursing includes service at Mercy Hospital, Bay City, Mich., Providence Hospital, Washington, and at Catholic University. Miss Berdan's article describing procedures used in a study of nursing services in the Public Health Service division of hospitals appears on page 80.

Dr. James K. Stack is a member of the attending surgical staff at Chicago's Passavant Hospital, whose staff offices he describes in the article starting on page 77. Dr. Stack is also a member of the Wesley Memorial Hospital staff and a member of the Northwestern University Medical School faculty. He is a graduate of Northwestern's medical class of 1931 and a diplomate of the American Board of Surgery.

When he writes about the advantages of group medical practice (page 96), **Dr. Dean A. Clark** is simply preaching what he practices. As director of the Health Insurance Plan of Greater New York, Dr. Clark is responsible for a program which combines the group practice and prepayment concepts on a large scale. A speaker at many medical, hospital and public health meetings, where he explains how H.I.P. works, Dr. Clark is an enthusiastic advocate of the group practice principle. He is a graduate of Johns Hopkins University Medical School and before joining forces with H.I.P. was a U.S. Public Health Service surgeon.

Robert E. Sleight is a member of the administrative staff of Memorial Hospital, New York, and a special student in hospital administration at Columbia University. . . . **Reba Staggs** is director of the department of home economics, National Live Stock and Meat Board, Chicago. . . . **E. A. van Steenwyk** is executive director of Associated Hospital Service of Philadelphia and former chairman of the national Blue Cross Commission.

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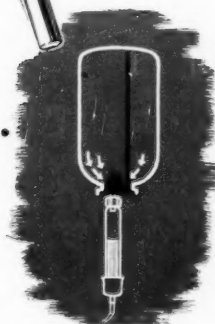
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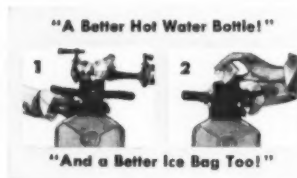
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Wesley Woos 'Em

Currently being circulated is "Welcome to Wesley," a handbook for the patient issued by the big Chicago hospital that looks like a cathedral, that sounds like a cathedral (organ music in the lobby) but that is colorful and home-like once you enter either a standard private room or a de luxe air conditioned room, depending upon your economic or emergency status.

Wesley does a smart job in its printed promotion always, and this newest item is strictly up to standard. Logically, the handbook's main divisions are "when you arrive at Wesley," "while you are at Wesley," and "when you leave Wesley"; under these groupings are all the necessary suggestions and regulations that do so much to orient the patient to his strange temporary environment.

The patient's questions satisfactorily answered, the manual switches to Wesley—as a teaching organization, as a home of research, as an institution with an interesting history, and as a philanthropic organization with a free bed fund. Not to cramp the calligraphy of a newly won donor, the handbook gives a whole page to a subscription form for the free bed fund—an inviting form on which one might like to practice a dashing signature.

A second color, a warm wood rose, is used in the booklet and this with large halftone plates, each of which tells a story, makes the job one that may well inspire a number of imitators.

In Such a Democratic Way

Phenomenal response to the sort of shock treatment they received at King State Hospital, New York, last fall was reported by a group of psychiatric nurses.

These nurses were summoned to a regional workshop by the state department of mental hygiene. They went with the idea that they were going to be lectured to, see demonstrations, and be brought up to date with respect to new technics. It did not occur to any of them, apparently, that theirs was to be any more than a passive rôle. For like nurses everywhere, used to taking orders and taking blame, they did not anticipate a creative or an argumentative part in the proceedings.

But this workshop was really a workshop. The commissioner of mental hygiene and the hospital directors were quick to recognize the value of the nurses' actual experiences on the wards. Thus encouraged, the nurses selected from their experience significant aspects of current procedures with respect to what is good and what needs to be changed. And they found their practical recommendations in regard to the care of patients being seriously regarded.

"These workshops are not a step forward, they are a leap," one nurse wrote after the week was over. "The chance for expression, pooling and exchange of ideas in such a democratic way was a wonderful experience for us all."

Other hospital groups, please copy

Glamour Goes to Work

Glamour can conceal a warm heart—but not for long. It appears that training beautiful models to do their stuff is not such a fascinating job as some outsiders may imagine. In fact, one of the best trainers of models gets bored with so much beauty now and then, so she turns to her self-created hobby—teaching crippled children to walk.

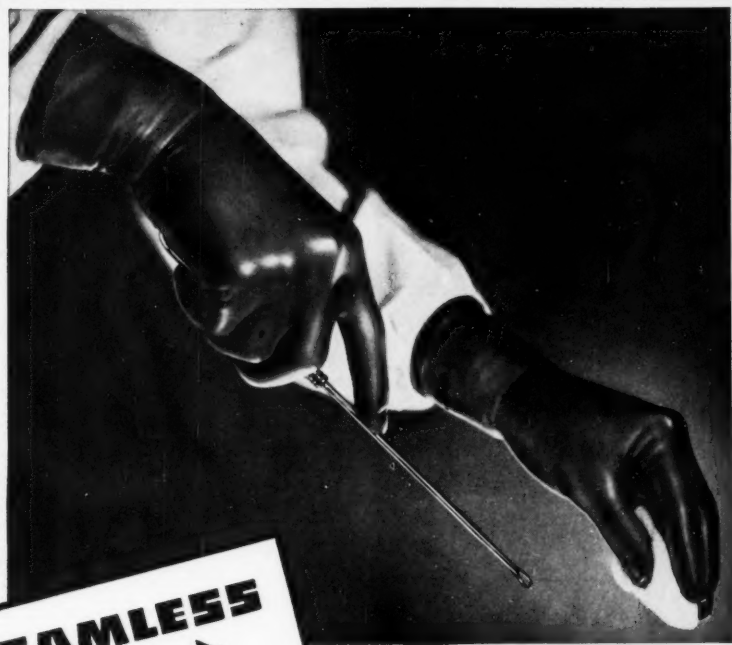
Estelle Compton, a glamorous example for the students of glamour, instructs at the National Models Institute in Chicago. She finds that within a few minutes she can determine the balancing potentialities of a crippled child and whether or not her technic of teaching models to walk can be applied to them. Her subjects are chiefly crippled children from St. Vincent's Orphanage in Chicago.

Miss Compton has been successful even with two spastic patients whom nurses and attendants had not been able to teach to walk.

The point of this is not to glorify Miss Compton, for she gets sufficient satisfaction out of her hobby, but to spread the word that she would be glad to pass on her skill in this regard to orthopedic nurses who have many such children under their care. She will give her time without charge.

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Reader Opinion

Heart of the Problem?

Sirs:

I wish to call to your attention the article appearing in a recent issue of *The MODERN HOSPITAL*, entitled "At the Heart of the Hospital Problem," by Lawrence Drake. It is my personal feeling that Mr. Drake's article has done

little good to the hospital field and I am rather surprised that you promulgate this type of article.

In the article the writer denies any criticism of hospital superintendents, but his denial is so worded as to imply the opposite. There are many hospital administrators who have donated count-

less hours of unpaid effort to their hospitals with little gratitude and appreciation. Many of these unsung hours have been devoted to the thinking out of administrative or "executive type" decisions. I would take it that Mr. Drake's acquaintanceship with the hospital field is rather limited. He states that he does not "know of a single hospital superintendent who has the authority to act in matters involving the medical profession according to his best lights and judgment." The entire point of the article is probably aimed at helping the voluntary hospital, but I certainly feel that statements and implications such as Mr. Drake's are rather unnecessary.

Edward J. Dailey Jr.
Phoenixville Hospital
Phoenixville, Pa.

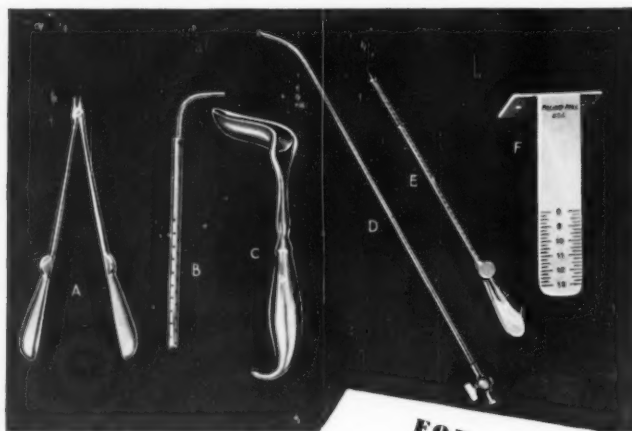
Sirs:

The substance of the comment on my article reveals a very familiar dual attitude: (1) "Here I am working like a dog, and with little thanks, and you criticize me." (2) "It's dangerous to make such criticism public." The possible justification for the first, that the hospital administrator is a little-appreciated and self-sacrificing public servant, is denied by the second, which reveals a morbid fear of the public.

It was repeated experience with this split attitude that led me, in the first place, to plan a paper that might show the hospital administrators the wisdom as well as the necessity for a different attitude toward the public. My article was not naïvely critical. A person who underestimates the public and is afraid of the public cannot hope to solve what is fundamentally a public relations problem. And one that involves not disarming the public, but winning it to active support of an institution.

When I prepared my paper, I took a stand that was contrary to the one taken by many of my hospital and medical friends, who were counting on a Republican victory and were quite certain that the threat of large-scale government intervention in the medical and hospital fields was shortly to end. I didn't know, to be frank, who was going to be elected. But I knew that in the long run it wouldn't make any difference. Economic and social forces, shaped

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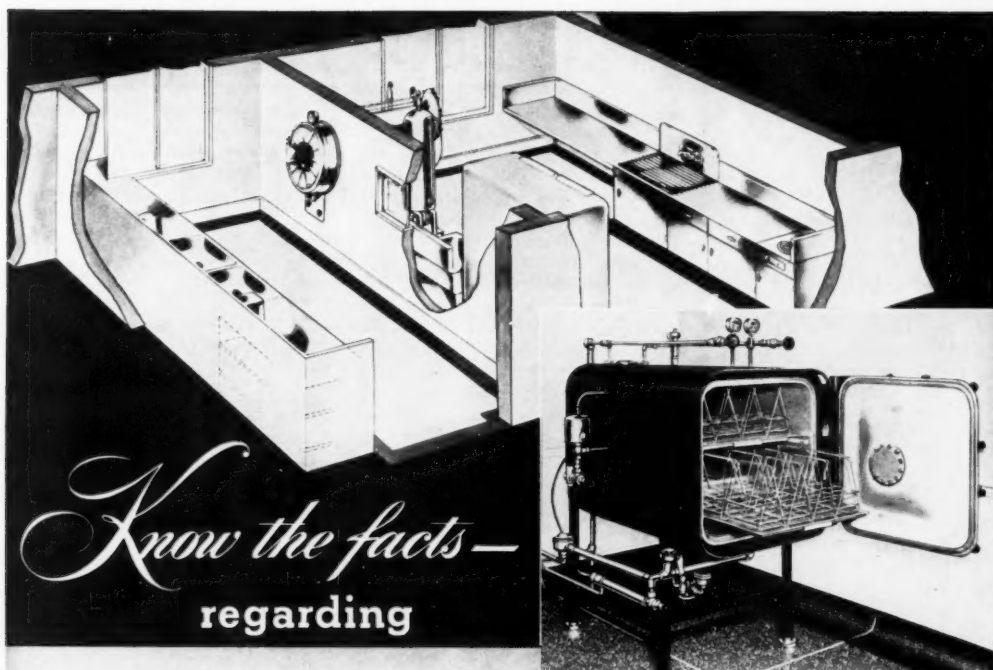
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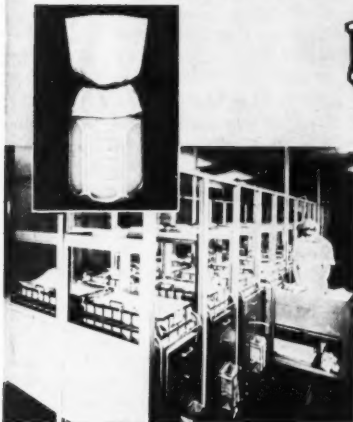


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by the uncontrollable dynamics of our national life and activities, have projected a hospital service that must and will serve the broad masses. Politicians count only so long as they know how to go along with the living historic forces. When they forget that history casts them aside. A hospital and medical service that will meet the needs of the masses of people is in the cards. Nothing short of a social catastrophe will stop that. That certain segments of the public are opposed to this will make no difference. Public opinion was predominantly pacifist in the Western countries before World War II, which didn't stop the war, or prevent it. Public opinion is a historic force only in a secondary sense, but an effect of material and economic forces in the primary sense. As I saw it, the hospital as an integrated service, serving the millions, was inescapable. Truman or Dewey, we were certain to get it.

The problem, as I stated it in my paper, was this: How can we go along with the hospital that is historically inevitable, yet negotiate the deal in such a way that the result will be an institution consistent with our way of life and our society? The answer to this question impinges on the hospital administrator. Unless he can be aroused to understand the rôle it is his to play we can have no hope of meeting the problem with any success.

Our voluntary hospitals are in a precarious condition. The threat of government medicine is far more real today than it was at the time when I wrote the paper. The only way we can escape government intervention is by vastly improving our methods for selling the voluntary hospital, as voluntary hospital, to the public. That our hospital administrators often work hard, and with little thanks, is true. But that has nothing to do with the question.

As a layman, my interest in the hospital administrator is limited entirely to the public aspects of his job and rôle, as these involve the survival of the voluntary hospital. I pointed out that the type of analysis we need to guide the voluntary hospital to a dynamic and historically effective public relations program is available. The questions I raised were simple enough: To whom in the hospital can we offer this analysis and program? Who is there in the hospital to assume the responsibility for as well as to provide the leadership for such a program?

To whom and who? These are the questions. No sane man is going to pre-

fer a free-enterprise peritonitis to a socialistic appendectomy. And so long as sane people can vote political sanity and therefore political inevitability is going to be on the side of the appendectomy, call it what you will. I, as a layman, am willing to help with the problem of saving our voluntary hospitals. Of saving them, however, and not muddling into socialism. To whom can I go to offer my help? Whom can I work with? The rest is immaterial.

Lawrence Drake

Washington, D. C.

Explosion Hazard

Sirs:

The December issue of *THE MODERN HOSPITAL* carries an article entitled, "Avoidable Tragedies," which deals with the hazard involved with the use of anesthetic gases. It is a most timely warning to administrators who have ignored the safeguards that should be employed in the surgical suite in the presence of volatile gases, but I find in this editorial an element of danger in one sentence. "Many authorities believe that the association's recommendations concerning the installation of explosion-proof operating room lights are needlessly severe and expensive provided other safe practices are rigidly in force."

Who are these many authorities? Certainly, they are not to be found in the administrative group or among the professional hospital consultants. This statement is an excellent crutch for the indifferent administrator to lean upon and might, to some degree, encourage a "me, too" attitude.

Recently we have been surveying the problem of anesthetic hazard and were obliged to import a consultant from Boston, Mass. Apparently, a qualified physicist is the type of expert to deal with this problem.

Every hospital administrator should review the anesthetic hazard problem periodically to ascertain that the various safety regulations are being complied with and he should also keep abreast of the newer developments that afford greater protection for both patient and personnel.

E. Atwood Jacobs

Reading Hospital
Reading, Pa.

The qualifying clause, "provided other safe practice regulations are rigidly enforced," seems to us to make it unlikely that this article can be used as a crutch for the indifferent administrator to lean upon.—Ed.



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Stainless steel. Combines viewing box, solution warmer and instrument cabinet.





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Precipitron*



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* Reg. U.S. Trademark

BE SURE...IF IT'S Westinghouse

One reliable source for Everything Electrical... to distribute, control and utilize electric power

Badly needed expansion of both government and private hospitals is now bringing construction programs to an all-time peak.

For this type of construction, as well as all other commercial and industrial buildings, Westinghouse offers architects and contractors a unique advantage. *Everything electrical*—from distribution and control apparatus to highly specialized x-ray and lighting equipment—can be obtained through one reliable source.

By centralizing responsibility with Westinghouse for power distribution equipment, construction and building equipment, heating and ventilating equipment and lighting units, you gain important advantages:

1. SPECIALIZED ENGINEERING... to assist in selecting and applying equipment for maximum efficiency.

2. SIMPLIFIED ORDERING... by providing a focal point of contact for all buying and specification data.

3. SPEEDIER INSTALLATION... by centralizing responsibility for delivery and installation.

4. BETTER, MORE RELIABLE SERVICE... through the co-ordinated design and construction of Westinghouse equipment, plus broad experience in applying it for all types of buildings. Westinghouse also offers unmatched electrical maintenance service, through its nationwide chain of Renewal Parts Warehouses and Manufacturing and Repair Shops.

Call your nearest Westinghouse District Office or Distributor for full information on this co-ordinated service. When there's **CONSTRUCTION AHEAD** requiring electrical equipment of any kind... you can be *sure* if it's Westinghouse.

J-94782



PRACTICAL, EASY-TO-USE BUYING INFORMATION

Architect's and Engineer's Data Book—B-2161-D

This 362-page book contains data on all Westinghouse products for the building industry. Its format is adapted to the needs of the architect and engineer. Ask your nearest Westinghouse office for a copy.

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PLANTS IN 25 CITIES... OFFICES EVERYWHERE



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THAT ALSO OFFER US
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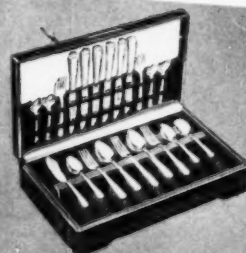
PEOPLE WHO TALK ABOUT GOOD FOOD...



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A quick reading of General Foods Prize Catalog proves several facts. There are hundreds of delightful gifts available. Some cost only a few coupons, some cost hundreds of coupons. Almost any of them are yours if you'll begin saving the prize coupons packed with almost all General Foods Institution Products. Get your copy of the Prize Catalog right away.



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...TALK ABOUT GENERAL FOODS!

IT'S NEW

ANTISEPTIC SEPTISOL *Surgical Soap*

Containing G-11*

ANTISEPTIC SEPTISOL is a concentrated liquid surgical soap containing hexachlorophene, commonly termed G-11* in recent medical literature. For preoperative scrubbing, it offers these major advantages:

● **GREATLY SIMPLIFIES SURGICAL SCRUB-UP ROUTINE**

ANTISEPTIC SEPTISOL accomplishes superior bacteriological cleanliness of the skin in less than 1/2 the time required for conventional scrub-ups.

● **MAKES BRUSH SCRUBBING UNNECESSARY**

The marked effectiveness of ANTISEPTIC SEPTISOL eliminates the need of scrubbing brushes.

● **ELIMINATES NEED FOR ANTISEPTIC RINSES**

Alcohol and iodine rinses which often defat and irritate the hands are unnecessary, because of the thorough antiseptic effect of ANTISEPTIC SEPTISOL.

● **OFFERS ACCUMULATIVE PROTECTION FOR SKIN**

A bacteriostatic film accumulates on the skin with repeated use of ANTISEPTIC SEPTISOL, maintaining bacterial population at extremely low levels.



The precision built SEPTISOL Soap Dispenser has been the choice of leading hospitals for years. Available in 3 models. Write for information.

Other Uses...

ANTISEPTIC SEPTISOL, because of its marked antiseptic value, has many recommended uses...

- For routine and preoperative use on patients.
- For the cleansing of traumatic wounds.
- For the various uses of soap in obstetrics and gynecology.
- As an aid in the prevention of pyogenic skin infections.
- For the routine use of nurses, ward attendants, food handlers and other kitchen personnel.

ATTACH COUPON TO YOUR LETTERHEAD AND MAIL TODAY!

MH

VESTAL INC., St. Louis 10, Mo.

- ☐ Please send a free copy of your Booklet, ANTISEPTIC SEPTISOL, including the medical research data on G-11.
- ☐ Please quote prices for ANTISEPTIC SEPTISOL.
- ☐ Please mail a FREE sample of the new ANTISEPTIC SEPTISOL.

NAME _____

TITLE _____

To simplify the elaborate, lengthy preoperative scrubbing techniques that have been practiced to safeguard surgeons, obstetricians, hospital personnel and patients, a truly effective antiseptic soap has been developed: ANTISEPTIC SEPTISOL.

Since the usual scrub-up technique consists of such harsh measures as a 12 to 15 minute brush scrubbing with soap followed by antiseptic applications of alcohol and/or iodine, it is apparent that ANTISEPTIC SEPTISOL fulfills a long-felt need for improving scrub-up procedures.

In addition, authoritative tests confirm that the reduction of skin bacteria is almost one-hundredfold greater with ANTISEPTIC SEPTISOL as compared to results obtained with ordinary surgical soap followed by germicidal rinses.

*G-11, the active ingredient of ANTISEPTIC SEPTISOL has been tested by prominent medical workers and bacteriologists for a period of more than five years. The results of these tests show that it is the only known germicide which is fully effective in combination with soaps.

VESTAL ST. LOUIS
NEW YORK
INC.

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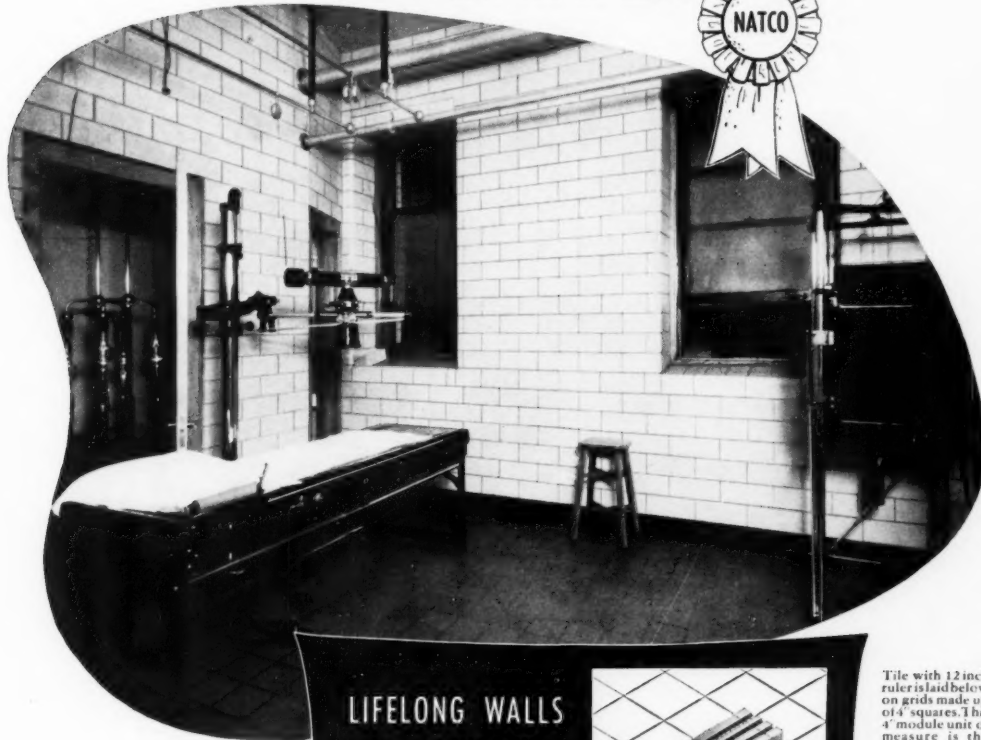
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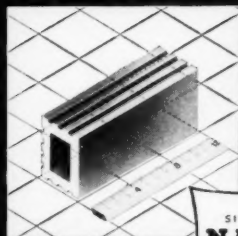
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GIVE THE PUBLIC THE BEST FOR ITS MONEY



NATCO Glazed Vitritile Facing Tile used in X-Ray Room, St. Francis Hospital, Pittsburgh, Pa.

LIFELONG WALLS
OF SANITARY,
SPARKLING
CLEANLINESS



Tile with 12 inch ruler is laid below on grids made up of 4' squares. This 4' module unit of measure is the basis of modular coordination for all building materials and equipment.

SINCE 1889
NATCO
CLAY PRODUCTS

Hospital walls that offer the ultimate in fire safety, enduring attractiveness and germ-resistant cleanliness—are walls constructed of Natco Glazed Structural Facing Tile.

They stay bright and cheerful and sanitary—needing only soap and water cleaning—for the life of the building.

First cost is last cost with Natco Glazed Structural Facing Tile walls—economical to erect—maintenance is negligible—and they last without deterioration for the life of the building.

Furnished in permanently attractive mottled and straight shades. Now available in modular sizes—little or no cutting needed on the job—means money and time saved—better workmanship—less material waste. Write for descriptive Catalog PF 47.



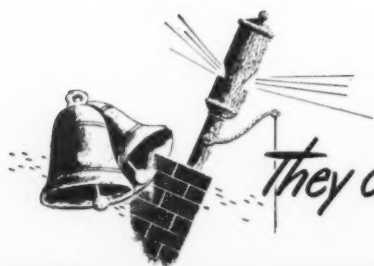
NATCO TILE FOR EVERY TYPE OF BUILDING

NATIONAL FIREPROOFING CORPORATION

GENERAL OFFICES 202 EAST OHIO STREET • PITTSBURGH 12, PA.

BRANCHES: New York • Chicago • Philadelphia • Detroit • Boston • Syracuse • North Birmingham

IN CANADA—National Fireproofing Company of Canada, Ltd., Toronto, Ontario



They called out the Fire Engines!



BOX SCORE
 Objective: \$ 850,000.00
 Raised : \$1,189,975.00
SUCCESS HIGHLIGHTS: A staff of 44 doctors gave \$81,425. Industrial employees gave \$309,917 . . . Corporate pledges reached \$325,263.

40% over the goal

Yes, the citizens of Elyria, Ohio, really celebrated. They held a big parade, complete with fire engines, bands and confetti . . . noise galore . . . sirens blowing, church bells ringing, and plant whistles screaming . . . all for the magnificent victory of the Elyria Memorial Hospital's building fund campaign.

Everyone was happy. 11,757 contributors had assured the hospital of a new

wing and complete modernization. What most people had thought "impossible" two months previously had been accomplished. Now civic leaders of this community of about 30,000 hailed the campaign as "the greatest thing that ever happened here."

Skilled professional direction, coupled with the enthusiasm and loyalty of volunteer workers, can often do "the impossible" as they did in Elyria.

Ketchum, Inc.'s 30 years experience in professional direction of fund-raising campaigns can easily make the difference between success and failure in *your* hospital campaign. Your inquiries are invited.

KETCHUM INCORPORATED

INSTITUTIONAL FINANCE

CAMPAIGN DIRECTION

CHAMBER OF COMMERCE BUILDING, PITTSBURGH 19, PA.
 500 FIFTH AVENUE, NEW YORK 18, N. Y.

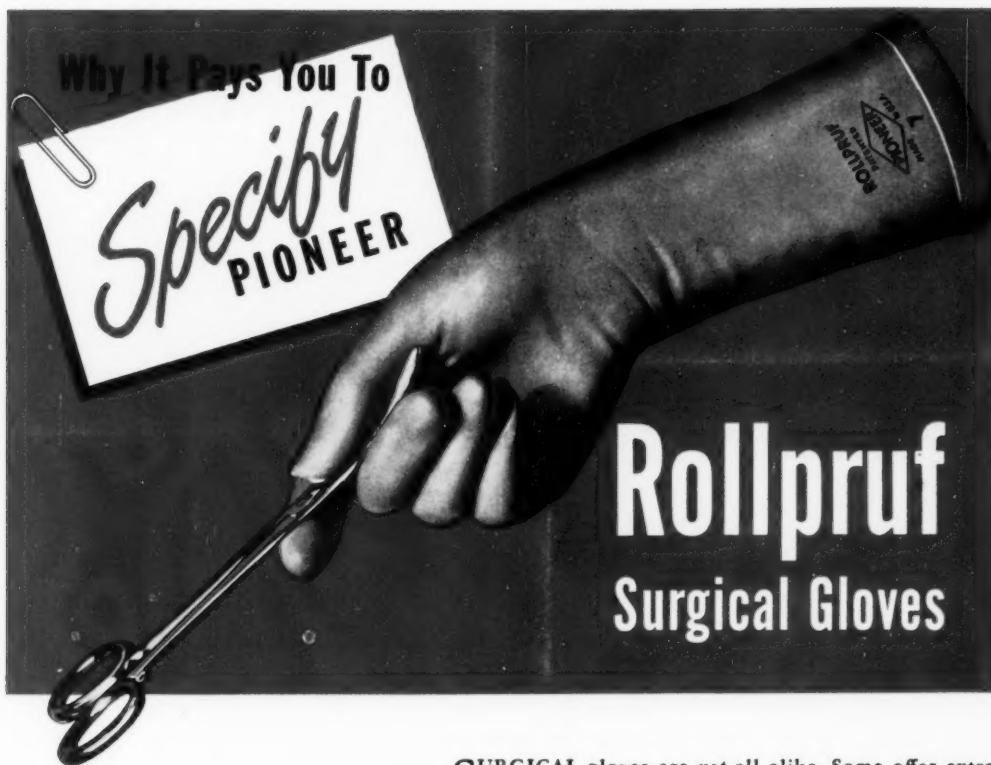
CARLTON G. KETCHUM
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MCCLEAN WORK
 Vice President



Member American Association of Fund Raising Council

Why It Pays You To
Specify
PIONEER



Rollpruf

Surgical Gloves

	
<p>Pioneer Obstetricals Made of finest quality latex, elbow length, sheer but tough. Either hand style so any two make a pair — saves pairing and odd gloves.</p>	<p>Pioneer Quixams Either-hand short wrist examination glove, now made of finest quality latex or neoprene. Any two are a pair — less cost.</p>

SURGICAL gloves are *not* all alike. Some offer extra advantages important to your hospital staff. Only by "specifying" can you be sure to get them.

For instance, Rollprufs are the only surgical gloves with beadless flat-banded wrists, no roll to roll down and annoy surgeon during operations. Banded wrists resist tearing, add to service life. Unsurpassed sheerness, snug fit, durability under sterilizing. No extra cost. *Specify* Rollprufs and get these valuable advantages.

Neoprene Rollprufs, now made in hospital green, offer all the above, plus unmatched comfort, finger freedom and sensitivity — and they're the answer to surgeons allergic to rubber. To give your hospital these advantages, specify neoprene Rollprufs.

When it's life or death in surgery, no equipment, including gloves, can be too good. It pays you to investigate — and specify — Pioneer Rollprufs. If your supplier doesn't stock them, write us for data and samples. *The Pioneer Rubber Company, 750 Tiffin Road, Willard, Ohio.*

PIONEER

Surgical Gloves

★ The Result of Over 30 Years of Quality Glove Making ★



Advances in Ob. and Gyn. Suturing

NEW CLINICAL PROCEDURES FAVOR NEEDLE SUTURES

Sutures swaged to eyeless needles are being more widely adopted for use in delicate tissues by Gynecologists. To meet this trend, Ethicon has developed a new group of 13 Ob. & Gyn. eyeless Atraloec needle sutures. There are 4 new needles, swaged to chromic gut, sizes 3-0 to 2.

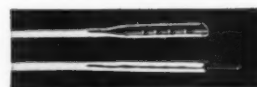
All Ethicon Ob. & Gyn. eyeless needles are swaged to Ethicon's Tru-gauged,* Tru-chromicized surgical gut, noted for superior strength and flexibility.

Ethicon sutures with swaged needles are supplied to hospitals at no extra cost over Standard Tubes. They are delivered in the new, unbreakable metal Sterile Pack canisters which guarantee sterility of tube exteriors.

*Selected, superior quality catgut specially finished to produce uniform diameter. All but a small part of our standard tube production is also Tru-gauged.



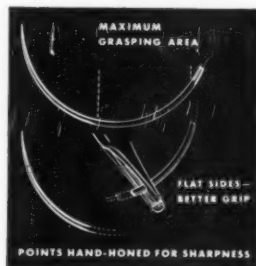
ETHICON SUTURE LABORATORIES
DIVISION OF JOHNSON & JOHNSON, NEW BRUNSWICK, N. J.



CONVENTIONAL SWAGE



ETHICON SEAMLESS SWAGE





Name Woven
Terry and Huck Towels,
Wash Cloths and Mats



Plain Terry
Towels, Crash and Huck
Towels and Toweling

Yes, MARTEX name-woven terry towels are built to last, to take brutal wear and repeated trips to the laundry. Their wear resisting construction starts at the foundation, in the plied yarn ground warp threads. Plied yarn ground warp threads are the basis of a durable towel.

On plain towels and toweling the name that is looked to for long, satisfactory wear is FAIRFAX. Sturdiness and ability to take hard usage have made FAIRFAX plain towels and toweling respected by economy seeking buyers. Carefully kept records of length of towel life in use would show that it is good practice to specify MARTEX name-woven and FAIRFAX plain towels and toweling on your purchase orders.

"MARTEX towels— just like I have at home!"

Said the floor super to the probationer—

"You'll find little things mean a lot to patients."

"Little things? What —"

"Oh, touches that remind them of home. Ever notice our towels?"

"Sure, they have the hospital name on them."

"Ever look at the label?"

"No, should I?"

"That label is MARTEX. When you show a patient that MARTEX label her face lights up. Often she'll say, 'Why it's MARTEX, just like I have at home.'"

"Gee, don't MARTEX towels cost a lot?"

"I've heard MARTEX towels last so long their cost is low."



products of WEST POINT MANUFACTURING COMPANY
WELLINGTON SEARS COMPANY, selling agents
65 Worth Street, New York 13, New York

BOSTON CHICAGO DETROIT ATLANTA PHILADELPHIA SAN FRANCISCO LOS ANGELES NEW ORLEANS ST. LOUIS

QUIET

speeds recovery



Sanacoustic* Ceilings provide it

• By having Johns-Manville install noise-quieting Sanacoustic Ceilings in the "noise centers," you can provide the quiet necessary for speedier recovery . . . and thus have more beds available for new patients.

Diet kitchens and utility rooms . . . corridors and lobbies . . . nurseries and wards are among the noise centers that are especially in need of sound control.

J-M Sanacoustic Units consist of perforated metal panels backed up with a highly efficient sound-

absorbing element. They are absolutely fireproof, verminproof, rot-proof. Can be painted and repainted without loss of acoustical efficiency. And they're so easy to clean, you save on maintenance.

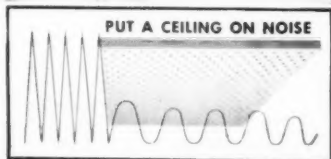
Let us tell you more about Sanacoustic Ceilings . . . and about J-M's *undivided responsibility* which includes expert installation by Johns-Manville to give you the *utmost in benefits*.

Write for brochure "Sound Control." Johns-Manville, Box 290, New York 16, New York.

*Reg. U.S. Pat. Off.

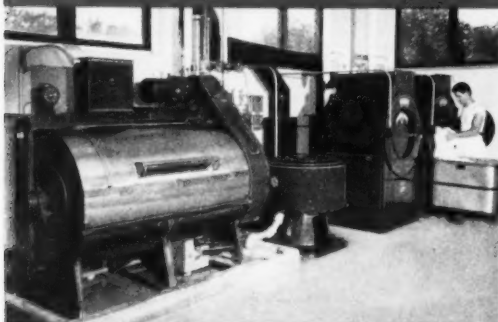


Johns-Manville
SANACOUSTIC CEILINGS



American...

MODERNIZED THE LAUNDRY DEPARTMENT AT 40-BED
MOTION PICTURE COUNTRY HOSPITAL, WOODLAND HILLS, CALIF.



In modernized laundry department are NORWOOD CASCADE Washer, American Extractor (for removing excess water from washed work), and 2 ZONE-AIR Drying Tumblers.

PROBLEM: Expanded facilities demanded increased laundering capacity. Household-type laundry equipment previously used had proved inadequate, undependable.

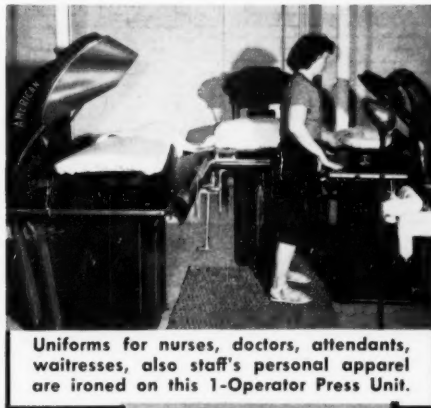
SOLUTION: Hospital requested services of our Laundry Advisor. He analyzed linen requirements, surveyed available space, then submitted recommendations and a suggested laundry layout. Hospital installed modern, cost-reducing equipment shown here.

RESULTS: Faster laundering provides an abundant, uninterrupted flow of sterile-clean linens to all departments. Linens and uniforms are more attractively laundered. High-speed equipment cut laundering costs to minimum.

Hospitals, *large or small*, can obtain the services of our Laundry Advisor. No cost or obligation. **WRITE TODAY.**



Linens are beautifully ironed on American RETRON Flatwork Ironer.



Uniforms for nurses, doctors, attendants, waitresses, also staff's personal apparel are ironed on this 1-Operator Press Unit.



Your hospital will benefit by selecting from American's complete line of most advanced and productive hospital laundry equipment.

REMEMBER . . .
Every Department of
the Hospital Depends
on the Laundry.

THE AMERICAN LAUNDRY MACHINERY COMPANY CINCINNATI 12, OHIO



Lead with the leader!

STERLING KITCHEN MACHINES

FIRST
with these
History-Making
Developments

in
DISHWASHING MACHINES

3-Way Door • Timed Rinse Valve
Hydro-Scrap Pre-Dishwasher
Zip-Lok Spray Tube Latch
Water Level Indicators, etc.

in
VEGETABLE PEELERS

Integral Peel Trap • Wavy Disc
Enclosed Base • Bonded-and-fused
Carborundum Abrasive

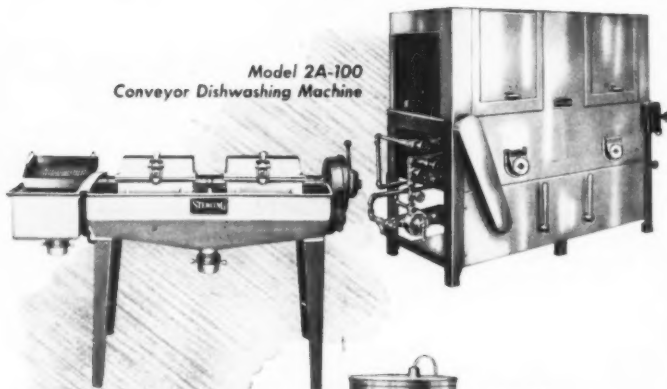
in
BURNISHERS

Pik-out Basket
Double Barrel—Double Covers
Solid Cast Bronze Barrels
Ball and Gas Trap
Positive Drive,
with Clutch Barrel Lock

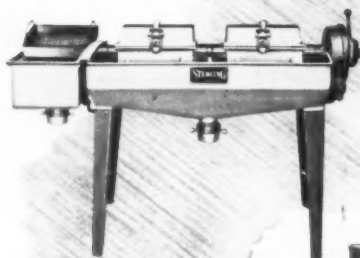
To maintain Sterling
leadership, new time-and
labor-saving features are
being perfected constantly.

● Stay ahead of competition! Specify **STERLING**, first in quality, first in efficiency, first in features. Enjoy the solid satisfaction of owning the best . . . of knowing that your equipment is so far out front that it will be best a long, long time. Enjoy, too, the feeling that your costs are cut to the bone with rugged, efficient, feature-packed **STERLING** Kitchen Machines.

Model 2A-100
Conveyor Dishwashing Machine



Model 61
Burnisher



Type A1
Vegetable Peeler



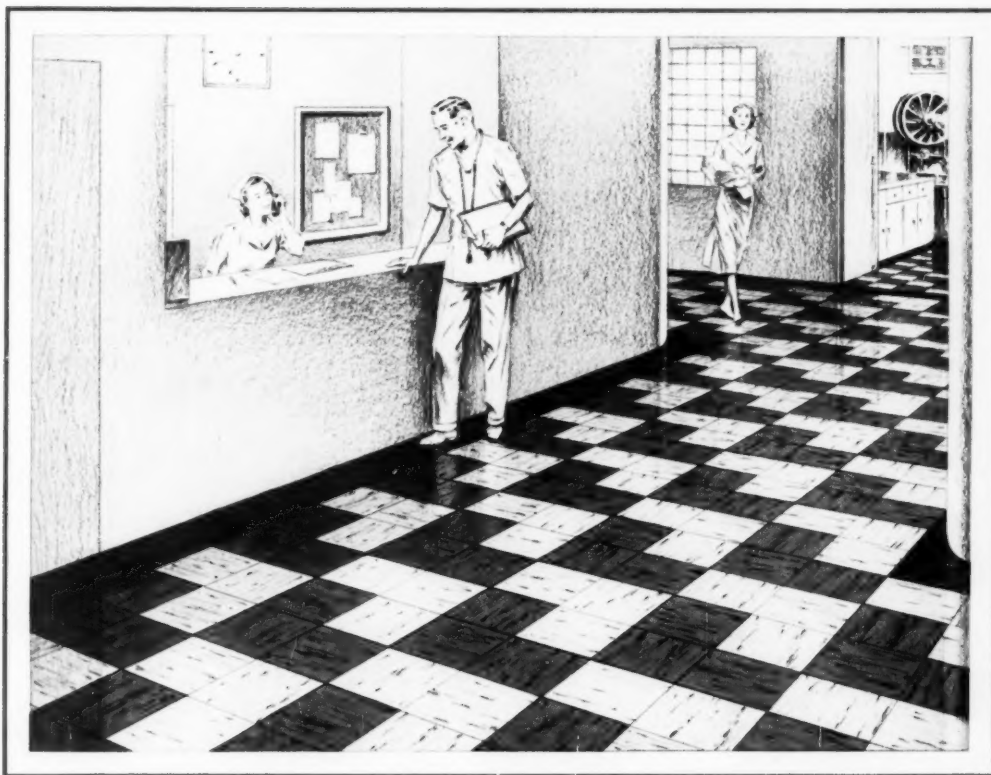
STERLING
NO. U.S. PAT. OFF.

The Standard of Quality

★ THE ANSTICE COMPANY, INC.
111 Humboldt St.
Rochester 9, N.Y.



*"Dr. Rogers looks
ten years younger!"*



“ We all know the importance of the right kind of flooring in hospitals . . . floors that are *quiet*, floors that are *durable*, and floors that are *easy to clean*. Several months ago, Dr. Rogers, in addition to all the usual decisions that a Superintendent has to make, had to choose new flooring for the hospital corridors and rooms. Well, today he looks like a new man! The floors have been in for more than a month and the nurses, doctors, maintenance crew,

everybody has been complimenting him on his choice. What *was* his choice? . . . Hood Rubber Tile!

Yes, wherever flooring beauty, longer wear (18 years in a Massachusetts hospital), ease of maintenance and comfort are of vital concern, the choice is Hood Rubber Tile. Write for free color catalog. See why leading American hospitals use Hood Rubber Tile.



HOOD—FOR RUBBER TILE

HOOD—FOR ASPHALT TILE

The right tumbler for every use...

THREE COMPLETE LINES OF LIBBEY ~~HEAT-TREATED~~ TUMBLERS

These famous Libbey "Bounce" Tumblers last from 3 to 5 times longer!

FOR ROOMS, trays, dining rooms and cafeteria use... wherever tumblers are used, there's a Libbey Heat-Treated Tumbler to do the job with economy. Patients and staff will appreciate these attractive, light, easy-to-hold tumblers.

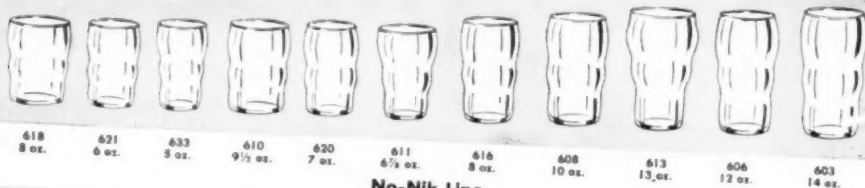
Hospitals and sanitariums from coast to coast praise Libbey Heat-Treated Tumblers because they last from 3 to 5 times longer

than ordinary glasses. Every one of these amazing tumblers is backed by the famous Libbey guarantee: "A new glass if the 'Safedge' ever chips."

Take advantage of the *extra economy* of Libbey Heat-Treated Tumblers! Request samples and prices from your nearest Libbey sales office or write directly to Libbey Glass, P. O. Box 1034-1035, Toledo 1, Ohio.

IT LOOKS BETTER... IT TASTES BETTER IN GLASS AND YOU CAN BE SURE IT'S STERILE!

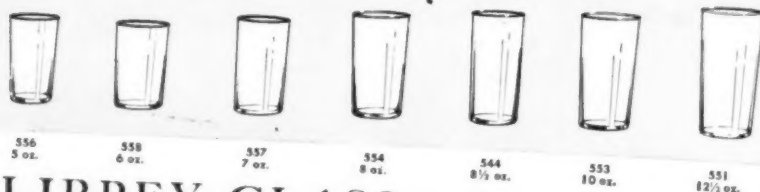
Governor Clinton Line



No-Nik Line



Straight-sided Line



LIBBEY GLASS **BOUNCE** TUMBLERS

Libbey Glass, Division of Owens-Illinois Glass Company, Toledo 1, Ohio



SAY...this is a sturdy CHAIR...



**It's long-wearing...beautiful
...comfortable, too!**

This new Wear-Ever Aluminum Chair "keeps up" without upkeep. It's strong! We loaded the chair with a 200 lb. weight, then rocked it mechanically 100,000 times—dropped it 4½" in each "rock." It remained tight and unchanged dimensionally! Made of high yield strength, extruded aluminum alloy, this chair levels itself on uneven floors.

There are years and years of wear-ability in this chair. The silvery Alumilite finish won't corrode, chip, crack, peel or show finger marks. Extremes in temperature and humidity do not affect it. No splinters to snag nylons. The tough, washable upholstery fabric will not fade.

Graceful, smart-looking, this Wear-Ever Aluminum Chair adds charm to any surroundings. Has black plastic finials and non-marring leg glides. Six rich upholstery colors: Red, Green, Blue, Ivory, Dark Green and Dark Brown.



SELF-LEVELING

Try this beautiful new chair. You will find the posture-perfect design and large formed seat and back always restful. Ask your supply house to show you this economical new Wear-Ever Aluminum Chair, or mail the coupon to The Aluminum Cooking Utensil Company, 703 Wear-Ever Building, New Kensington, Pa.



WEAR-EVER

Aluminum Chairs

We would like to see the new Wear-Ever Aluminum Chair:

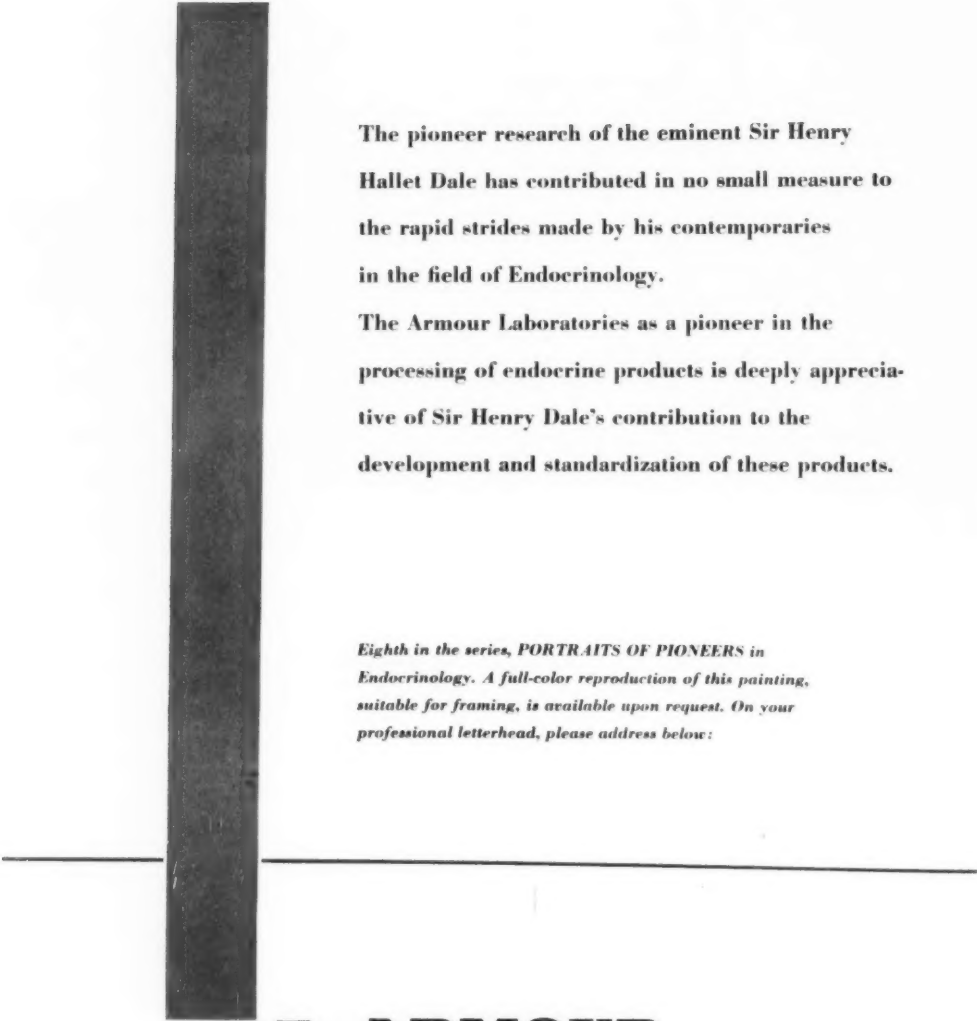
Color..... Also price on (quantity)....

Name..... Title.....

Firm.....

Address.....

City..... Zone..... State.....



The pioneer research of the eminent Sir Henry Hallet Dale has contributed in no small measure to the rapid strides made by his contemporaries in the field of Endocrinology.

The Armour Laboratories as a pioneer in the processing of endocrine products is deeply appreciative of Sir Henry Dale's contribution to the development and standardization of these products.

Eighth in the series, PORTRAITS OF PIONEERS in Endocrinology. A full-color reproduction of this painting, suitable for framing, is available upon request. On your professional letterhead, please address below:

 **ARMOUR**
Laboratories
CHICAGO 9, ILLINOIS



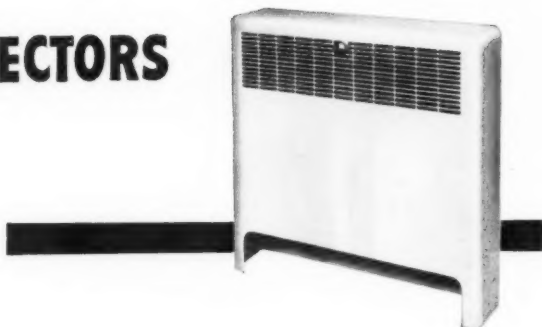
Sir Henry Hallett Dale ... 1875 -

The researches of Sir Henry Dale have influenced our concepts of endocrine physiology profoundly. The fundamental significance of his discoveries has come to be appreciated more fully with the years.

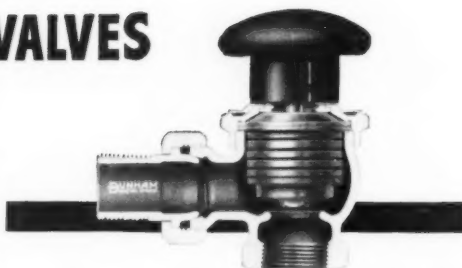
Sir Henry attended Trinity College, taking his medical degree at Cambridge and at St. Bartholomew's Hospital, London. He did research in physiology at University College under Professor Starling. In 1920 he became director of the department of biochemistry and pharmacology at the National Institute for Medical Research, becoming Director of the Institute in 1928. He was knighted in 1932. His major investigations began with an analysis of the pharmacology of ergot,

followed by research on histamine, particularly in relation to anaphylaxis and shock. While on this work he discovered the oxytocic action of posterior pituitary extracts. With Laidlaw in 1912, he published a biological method of standardizing such products. This method still is official in the United States Pharmacopoeia. He found acetylcholine in certain ergot extracts and studied its action. These studies led, after 20 years, to the epochal discovery by Otto Loewi that acetylcholine is the chemical intermediary in many instances between nerve impulse and muscular action. Sir Henry Dale was awarded, jointly with Dr. Loewi, the Nobel Prize for Physiology and Medicine in 1936.

From **CABINET CONVECTORS**



To **PACKLESS VALVES**



DUNHAM HEATING PRODUCTS *meet the needs of ANY JOB*

Increase operating efficiency . . . cut your costs

Regardless of what your heating equipment need may be . . . whether it's for a single valve or a carload of convector radiators . . . it will pay you well to look first at the Dunham line.

Dunham products are quality-built by heating specialists with a background of nearly half a century of experience.

Long a "buy-word" among the country's leading architects, contractors and engineers—they're easier to install, work better, require less maintenance—because they're precision engineered for their jobs.

Heart of the famous

Dunham Vari-Vac Differential System

It is upon these job-proved products that the Dunham Vari-Vac heating system is based—and

it is their reliable performance that has made possible the sensational savings in fuel for which this system is nationally famous.

So—if it's value you want, if it's quality you need, if it's performance you like—standardize on Dunham Steam Specialties, Unit Heaters, Pumps, Cabinet Convectors and Baseboard Convectors.

SEND FOR THIS CONDENSED CATALOG

Write today for your free copy of Bulletin 634C and get complete technical data on all Dunham heating equipment. See for yourself why value-wise architects, engineers and building owners the country over are talking and installing Dunham products to meet their every heating need!



C. A. Dunham Co., 400 W. Madison St., Chicago 6, Ill.

SALES ENGINEERS

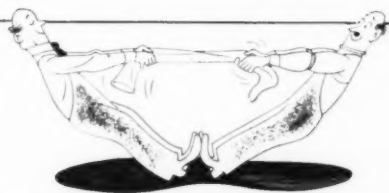
DUNHAM

AND JOBBERS IN ALL PRINCIPAL CITIES

HEATING MEANS BETTER HEATING

These are "Trying" Times

—be sure to try it before you buy it!



The Pull-the-Leg Test. You should see what a woman's stocking goes through before it reaches a leg. Wow! Snagging tests, abrasion tests, flexing tests, bursting tests, dye and fiber tests. But after all, it makes sense. Quality is determined *only* by test.



The Sleep-Like-a-Log Test. They use a mechanical Rip Van Winkle to test the quality of a mattress. Back and forth, back and forth a heavy eight sided roller passes over the mattress. If the mattress can stand up under 400,000 passes, you can be sure it's one of the best.

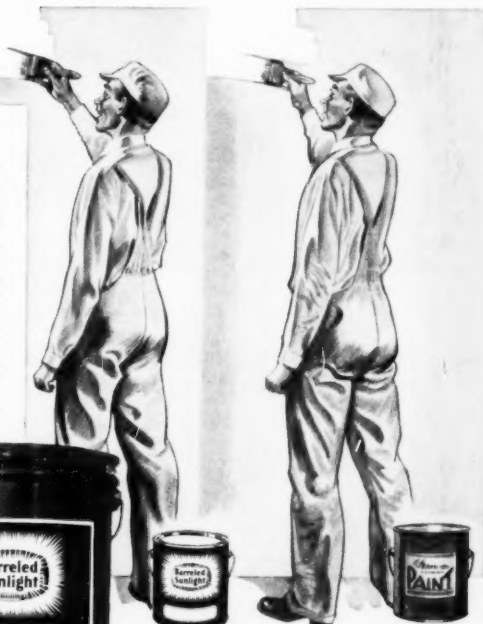
The Square Foot Test

One of the surest tests to find the best and most economical brand of paint to use in a building is the *square foot test*. Take a gallon of any good paint and a gallon of Barreled Sunlight. Thin each according to directions on the cans. Then measure the number of square feet each paint covers on a wall. And, because labor represents about 80% of the cost of any painting job, check the length of time it takes to apply each paint. Notice the difference in their appearance and hiding power after drying overnight.

Yes, compare any good paint with Barreled Sunlight. You'll see that Barreled Sunlight will do a better-looking, longer-lasting job at lower cost for both paint AND LABOR than any other paint on the market.

See for yourself. Let your nearest Barreled Sunlight representative give you a convincing demonstration. Write.

U. S. GUTTA PERCHA PAINT COMPANY
30-C Dudley St., Providence, R. I.



Barreled Sunlight

Paints



In whitest white or clean, clear, pleasing colors, there's a Barreled Sunlight Paint for every job

4 reasons why *"Lysol"* Brand Disinfectant outsells all other germicides



SAFE, EFFECTIVE UNDER DIFFICULT CONDITIONS . . .
even in the presence of pus, blood,
or any organic matter . . . so reliable is "Lysol."



A SINGLE ALL-PURPOSE DISINFECTANT
Non-specific "Lysol" is germicidal
for all disease-producing vegetative bacteria.



100 TIMES AS MUCH FOR YOUR MONEY
A gallon of economical "Lysol" makes
100 gallons of solution recommended for general
disinfection at only 2.4¢ a gallon.



AND WHILE GUARDING HUMAN HEALTH,
sterilizing with "Lysol" prolongs the useful life of
rubber goods, prevents rusting of expensive instruments,
guards delicate cutting edges.

YES . . . THOROUGH DISINFECTION AT A COST THAT MAKES SENSE.

That's the service "Lysol" has been providing hospitals,
clinics, labs for more than fifty years. THAT'S WHY
"LYSOL" IS STILL ON TOP OF THE GERMICIDE MARKET!

GUARANTEE: Every batch of "Lysol" is absolutely uniform
in composition and action, and free from impurities.

Address all inquiries to your
HOSPITAL SUPPLY DISTRIBUTOR
or to
LEHN & FINK PRODUCTS CORP.
Hospital Department
445 Park Avenue, New York 22, N. Y.



LIST PRICE

\$3.00 per gallon. *Save 20%*
by buying the fifty-gallon
drum. Supplied in 1-gallon
containers and in 5, 10, and
50-gallon drums. Leading
hospital distributors are
authorized to sell "Lysol."





A BACKGROUND OF DEPENDABILITY

For 61 years the Dundee name has identified towels of excellent quality and outstanding serviceability. That's why they are the choice of leading hospitals and institutions throughout the country who insist on towels firmly woven to give many repeat performances.

- Huck and Turkish Towels (plain and name woven) • Toweling • Damask Table Tops and Napkins • Corded Napkins

Consult your favorite distributor

Dundee Mills

INCORPORATED • GRIFFIN, GA.

Manufacturers of Famous Nationally Advertised

DUNDEE TOWELS

Showrooms: 40 Worth St., New York, N. Y.



Colorful



to brighten up your staff rooms & diet trays...

Of course, you recognize the appetite appeal and therapeutic value of cheerful looking china on your diet trays. But how about the psychological lift of colorful staff rooms, too — of china that sets the color scheme for the entire room, complementing or contrasting with the tint of the walls, the tops of the tables, or the seats of the chairs? These four new Syracuse China patterns offer possibilities that can be worked up into a variety of color schemes to suit a variety of moods and purposes. Ask your distributor, or write for color suggestions to the Creative Design Studios, Onondaga Pottery Co., Syracuse, N. Y.

ONONDAGA POTTERY COMPANY • SYRACUSE, N. Y.

**4 NEW
PATTERNS**

Mail this coupon
**TODAY for full
information...**

ONONDAGA POTTERY COMPANY
Syracuse, N. Y.

Please send me prices and further information on the following patterns:

() Whitfield () Graymere () Montrose () Colonial.

The dominant colors in my room are
The decorations are () solid colors () monochrome ()
striped () patterned () floral. Please send me your
suggestions for a china pattern.

Name _____ Title _____

Hospital _____

City _____ Zone _____ State _____



99 44 100 % pure ... it floats

It is not surprising that Ivory has won the acceptance of hospital authorities to a degree which perhaps no other soap has ever equalled. For pure, gentle Ivory serves efficiently — and pleasantly — the cleansing needs of everyone in the modern hospital.

Ivory today is finer than ever. It's richer lathering — even in hard water. It's handsomer ... easier to handle. And new, improved Ivory puts no heavy strain on hospital budgets.

* New, improved Ivory is available for hospital use in the popular unwrapped 3-ounce size. Also available in smaller sizes, either wrapped or unwrapped.

Procter & Gamble
CINCINNATI, OHIO

MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER . . .



Photo courtesy of
St. Vincent's Hospital, Sioux City, Iowa



Another Hospital Installs **TROY Laundry Machinery** to reduce costs and increase efficiency

Consistent promptness in delivering linens and uniforms ON TIME is essential. Hundreds of hospitals across the nation, such as St. Vincent's of Sioux City, have installed Troy laundry machinery to step up all-around efficiency and meet heavy schedules.

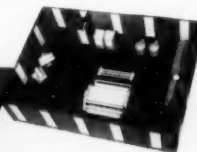
There is a Troy machine to quickly and capably handle each phase of laundry operation in less time, with less labor and at low cost. Speed, simplicity of operation, trouble-free maintenance and the keeping of linen supply inventories at a minimum are Troy advantages appreciated in busy hospitals.

WASHERS
EXTRACTORS
DRYING TUMBLERS
APPAREL PRESSES
FLATWORK IRONERS

TROY Laundry Machinery

DIVISION OF AMERICAN MACHINE AND UTILITY, INC.
EAST MOLINE, ILLINOIS

1600 Washington Boulevard, Chicago, Illinois 90000
104 West 34th Street, New York 1, New York



"PHOTO-PLAN" SERVICE

Troy laundry engineers survey your hospital laundry needs and plan most efficient layout. Scale models of laundry machines are set up on a miniature of your floor plan, then photographed and an easy-to-read three-dimensional print is furnished to you. No charge for this Troy service. Write for details.

BUILDERS OF QUALITY LAUNDRY EQUIPMENT SINCE 1868

PRATT & LAMBERT

PAINT AND VARNISH



MISSOURI DELTA COMMUNITY HOSPITAL, SIKESTON, MO.
JAS. GAMBLE ROGERS, Architect — ROGERS & BUTLER, Associate Architects, New York City
McCARATHY BROTHERS CONSTRUCTION COMPANY, General Contractors, St. Louis, Mo.
STANLEY HANKS PAINTING CO., Painting Contractor, St. Louis, Mo.

THE Missouri Delta Community Hospital and nurses' home, in pleasing Colonial design, is located on a spacious, landscaped site with an abundance of fresh air and sunlight. Equipped with the latest facilities, the hospital is meeting the demands of an ever-growing community.

Here, as in hospitals throughout the country, Pratt & Lambert Paint and Varnish not only serve to beautify and preserve, but contribute to the well-being of patients. Also it is now possible to supply certain P&L decorative materials free of objectionable odor, which are so obviously desirable in hospitals. Because of their extreme durability and washability, these products cut maintenance costs to a minimum.

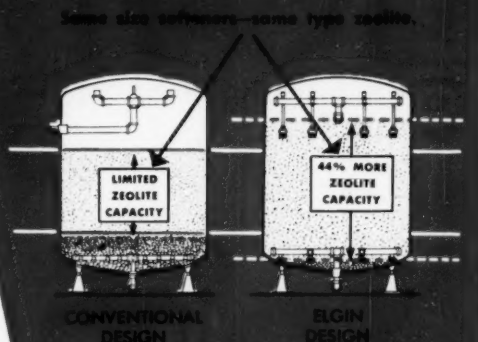
On request, you may have the co-operation of a Pratt & Lambert representative in developing complete color plans and painting specifications. Pratt & Lambert-Inc., 126 Tonawanda Street, Buffalo 7, N. Y.
In Canada, 18 Courtwright Street, Fort Erie, Ontario.



Save the surface and you save all!

1849 — Pratt & Lambert Hundredth Anniversary — 1949

Still the Biggest Water Softener Development in Recent Years!



Zeolite is a remarkable mineral—an ideal means of softening water—but . . . it remained for Elgin to introduce a method of making the zeolite softener get down to business and really do things in a big way.

This development—the Elgin "Double-Check" Softener—is still the biggest water softener development in recent years!

Like all basic changes its story is simple. By preventing the escape of zeolite under all conditions, the Elgin "Double-Check" manifold permits putting more zeolite in a softener of given size. Since it's the zeolite that does the softening, this means more gallons of soft water per regeneration.

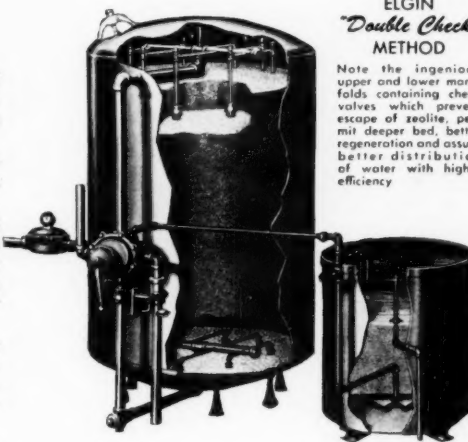
But notice, also, that by preventing the escape of zeolite a high backwash rate can be used which means better opening up and regrading of the zeolite bed, better regeneration by the brine, more efficient use of the zeolite throughout the service period.

That is why hundreds of users of the Elgin "Double-Check" report that it gives up to 44% more soft water per regeneration than any other softener of equal size. Yes, 44% more soft water from a softener of the same size containing the same type of zeolite. To you this means either added capacity from the same size softener, or the same capacity from a smaller one . . . always with a real saving in original investment, operating, and maintenance costs. Ask for Bulletin 607 containing eye-opening details.

ELGIN SOFTENER CORP., 144 North Grove Ave., Elgin, Ill.

ELGIN "Double Check" METHOD

Note the ingenious upper and lower manifolds containing check valves which prevent escape of zeolite; permit deeper bed, better regeneration and assure better distribution of water with higher efficiency.



Extra gallons of soft water from your present softener!

This Elgin development is adaptable to all makes of existing softeners. Let us show you how we can step up the output of your present softener (as much as 3 to 10 times with our new high capacity synthetic and resinous zeolites) . . . just as we have done it in hundreds of plants.



NOW AVAILABLE THROUGH ELGIN— ILLCO-WAY DE-IONIZERS

. . . for de-mineralization of water

ILLCO-WAY

By joining the services and products of the Illinois Water Treatment Co. with Elgin Softener Corp., the already wide range of Elgin services is further broadened to include Illco-Way De-alkalizers for boiler makeup, De-mineralizers and special Ion-exchangers. Ask for data.

SOFTENERS • CHEMICAL TREATMENT • FILTERS • ILLCO-WAY DE-IONIZERS

"Sound prescription" for Clean, cheerful INTERIORS



SCHOOLS



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DAIRY PRODUCTS



PACKING PLANTS



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DRUGS & CHEMICALS



FOOD PROCESSING



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PUBLIC BUILDINGS

hospital patients and budgets... of Facing tile

Here's a really sound "prescription" for the hospital you build—Structural Clay Facing Tile.

With it you get a compound of these many valuable ingredients:

One part of cheerful interior finish. Facing Tile banishes "sickroom atmosphere." Its bright surfaces can be in pleasant, light-reflecting color patterns, or clean, cool white.

A full measure of maintenance advantages. Facing Tile washes clean, quickly and easily, with soap and water. Its impervious surface resists steam and most acids. It will not harbor bacteria or any other unsanitary trouble maker.

A double portion of economy. Facing Tile is fast-building, long lasting. It's a structurally strong, firesafe wall and finish in one material, at one cost! It never needs painting or redecorating, never needs repairs for cracking, marring or decay, even after years of hard wear!

For healthier budgets and happier patients in your hospital, you can "prescribe" Facing Tile with confidence. For complete information contact any Institute member or write us, Desk MH-3.

SEND FOR YOUR FREE COPY OF 1949 FACING TILE CATALOG! This valuable file-size book gives you latest specifications and descriptive data in complete detail. Also pictures and information on a wide variety of Facing Tile installations. Just write us on your letterhead, Desk MH-3.

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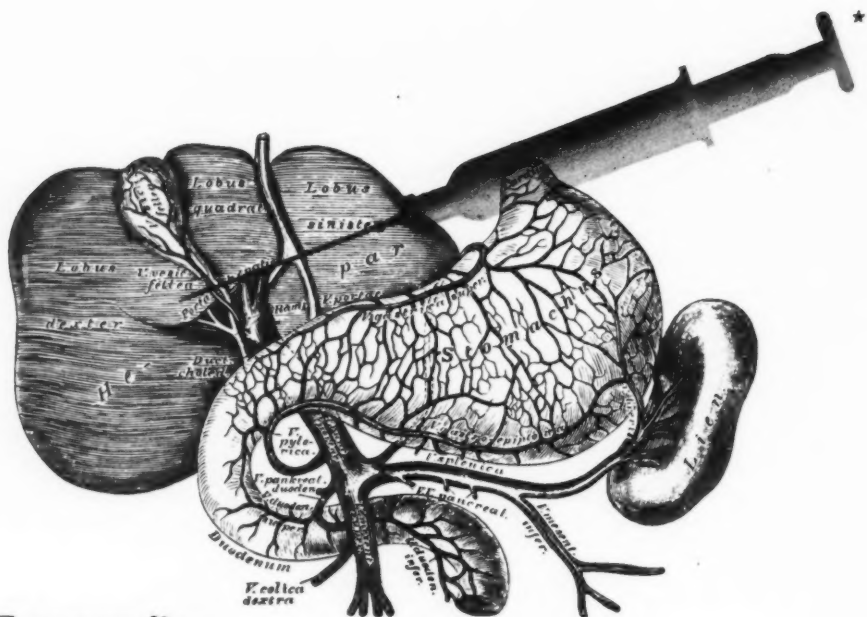
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expanding fields for hippuran

*HIPPURAN**, for years the medium of choice in excretion urography, is now proving of great value in the study of gallbladder function, both on the operating table and postoperatively.¹

If the surgeon wishes to discover whether the common duct has been cleared before closing, 10 cc. of HIPPURAN (N.N.R.) may be injected and a film taken at once. The obstruction has been cleared if HIPPURAN passes readily into the small bowel.

Some prefer to make the study through a T-tube after the operation. Stones lodged in the hepatic and common ducts may be visualized.

HIPPURAN — sodium ortho-iodohippurate — is an excellent and safe medium for retrograde pyelography and has been used for oral and intravenous urography.

¹ Simonds, F. L.: Opaque media in X-ray diagnosis, Nebraska State M. J. 31: 326-329 (August) 1946.

*Trade Mark Reg. U. S. Pat. Off. Hippuran U. S. Pat. No. 2,135,474.

82 Years of Service to Chemical Users

Mallinckrodt Chemical Works

Uniform, Dependable Purity

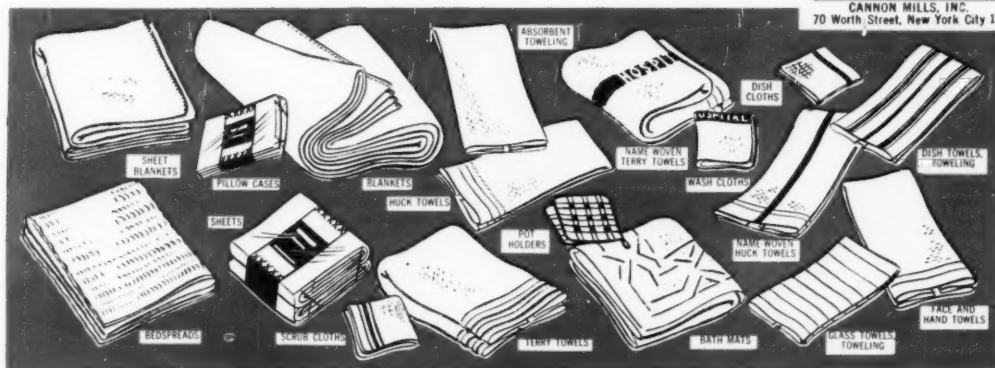


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SPEAKING OF COVERAGE . . .

Cannon's coverage of textile items for hospitals is *this* good.
Your supplier can provide you with all 18 Cannon items — promptly. *



MEDART STEEL LOCKERS

"The Standard-of-Comparison"

Medart Steel Lockers are famed throughout American Industry, Schools and Institutions as the locker by which all locker equipment is measured . . . from their sturdy long-life construction details to their special features which insure perfect security, cleanliness and maintenance-free operation. Feature for feature . . . dollar for dollar

. . . Medart Steel Locker is the STANDARD OF COMPARISON! For detailed information on Medart Lockers write for Medart Catalog. For answers to your installation problems consult Medart engineering department . . . entirely without cost or obligation.



MEDART SINGLE TIER LOCKERS

In either of two standard heights . . . 60 inch or 72 inch. Both provide full length coat compartment with shelf at top. Finished in olive green or brown enamel.

MEDART DOUBLE TIER LOCKERS

When full height is not required . . . or when economy of floor space is the watchword double tier lockers adequately fill the requirements of safe, sanitary storage. In olive green or brown enamel finish.



Single-Tier Lockers						Double-Tier Lockers					
Width	Depth	Height	Width	Depth	Height	Width	Depth	Height	Width	Depth	Height
12"	12"	60"	12"	15"	72"	12"	12"	30"	15"	15"	36"
12"	15"	60"	12"	18"	72"	12"	12"	36"	12"	12"	42"
12"	18"	60"	15"	15"	72"	12"	15"	36"	12"	15"	42"
15"	15"	60"	15"	18"	72"	12"	18"	36"	15"	15"	42"
15"	18"	60"	18"	18"	72"						
			18"	21"	72"						

MEDART LOCKERS AND CABINETS FOR EVERY STORAGE NEED

FRED MEDART
PRODUCTS, INC.
3535 DE KALB ST., ST. LOUIS 18, MO.

HANOVIA'S HIGH INTENSITY ULTRAVIOLET QUARTZ LAMPS

for
group
irradiation



Effective, economical and always available for hospital service, this remarkable Hanovia Lamp makes it possible to irradiate as many as six patients at one time.

This cuts down personnel, reduces cost of service, permits more efficient work in Ultraviolet therapy and effects a substantial saving.

Many hundreds of dollars can be saved annually by this group lamp. One technician can treat a large number of patients every day.

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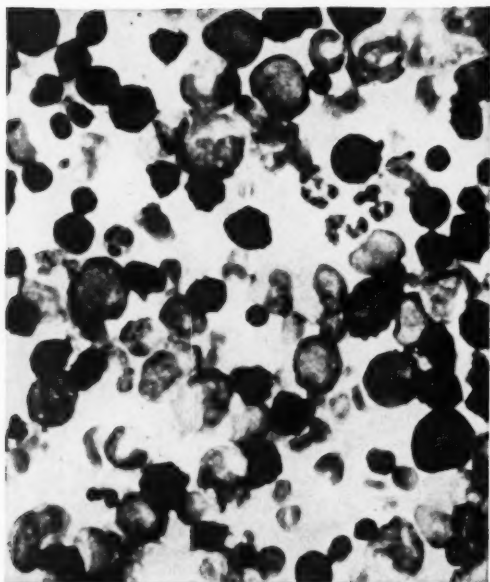
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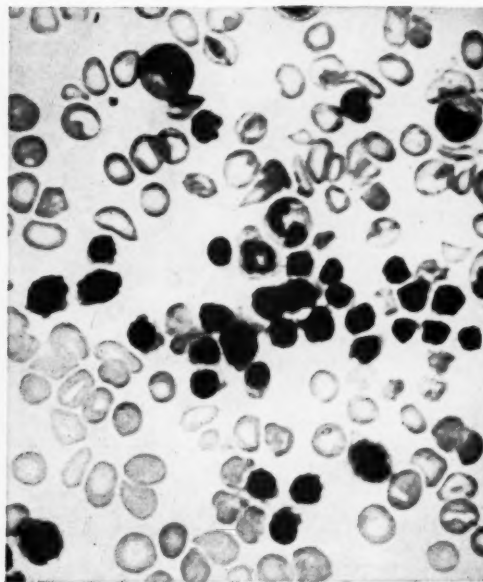
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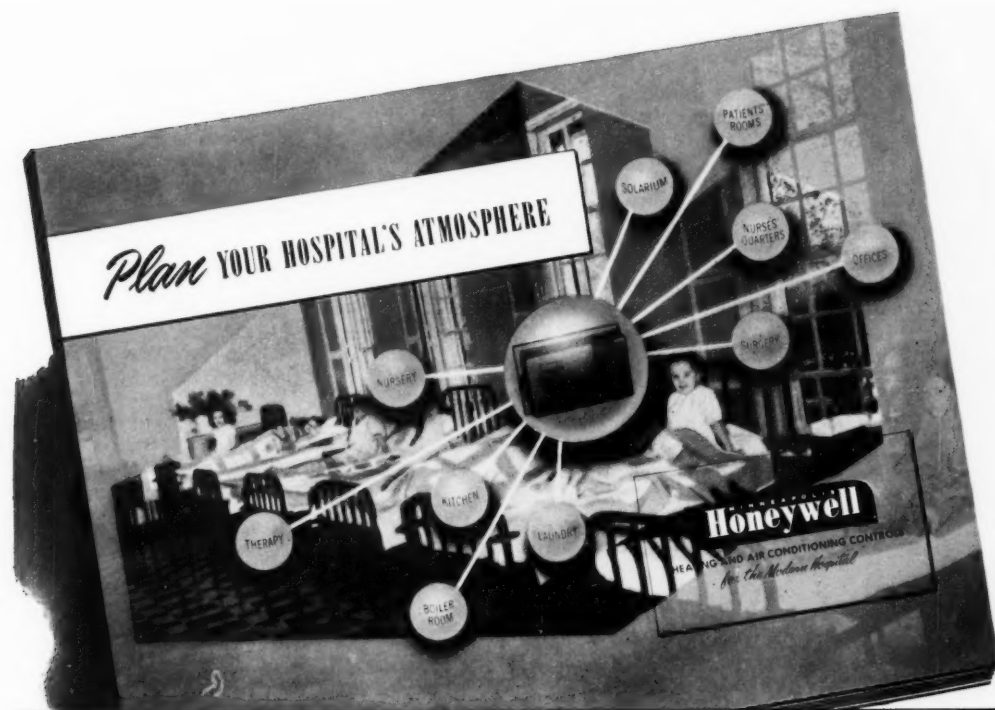
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Small Hospital Questions

Responsibility for Sponges

Question: If a surgical sponge is alleged to have been left in an abdomen, how much responsibility can be placed upon the nurse who is expected to keep the sponge count?—F.S.B., Conn.

ANSWER: From the standpoint of legal responsibility, the nurse who keeps the sponge count is a member of the operating team and is, therefore, an agent of the surgeon who carries the responsibility, even though she may be a regular salaried employee of the hospital.

Sometimes when litigation develops following an accident of this kind, the surgeon and his assistants, the hospital and the nurse are all named as defendants. However, it is the surgeon who carries the responsibility and I know of no cases in which courts have brought findings against the other defendants. Obviously, a hospital involved in litigation of this kind is in a better position to defend its case if it can be demonstrated clearly that accepted sponge count and control procedures had been instigated and carried forward conscientiously.—R. W. D.

Length of Vacation

Question: Where nurses work forty hours per week should more than a two week vacation be allowed?—E.H.J., Nev.

ANSWER: At a recent meeting of a hospital association in an eastern state this question came up for discussion, and the following information was obtained from administrators attending the meeting: eighteen hospitals had a 40 hour work week; one hospital had a 41½ hour work week; one hospital had a 42 hour work week; eight hospitals had a 44 hour work week; one hospital had a 44½ hour work week, and four hospitals had a 45 hour work week.

Among the hospitals having a 40 hour week, vacations vary from two weeks in the first year of employment and one month in subsequent years to three weeks or more for all employees.

Plastic v. Rubber Sheeting

Question: We are interested in receiving a comparison as to the relative value of synthetic or plastic sheeting and the regular rubber sheeting furnished to hospitals.—J.McL., Ill.

ANSWER: There has been a decided change, brought about by war-induced shortages of rubber material, in the at-

titude of hospital administrators toward the use of synthetic or plastic mattress protective sheeting in hospitals. Many people today are expressing the thought that the synthetic sheeting is actually superior to rubber sheeting. The important thing to bear in mind is always to purchase sheeting which meets the provisions of the commercial standard on this material, CS 144-33, issued by the National Bureau of Standards in cooperation with the Committee on Purchasing and Standardization of the American Hospital Association.—E. W. JONES.

Insurance Against Mistakes

Question: Provided we obtain the services of a recognized hospital architect, is there any way we can insure against mistakes in design or planning that won't be discovered until our building is in operation?—M.M., Ill.

ANSWER: Of course, a great many of the mistakes made by architects can be laid directly on the doorstep of hospital officials, because of the lamentable lack of a carefully thought out, well prepared written program for the architect. A vast majority of hospital executives and their board members now appreciate the utter folly of trying to carry forward a building or expansion program without the services of a competent architect and if necessary a consultant. However, if every architect having a hospital project to work out could put on an orderly's uniform and work on a nursing unit for just a week, we would have the best possible therapeutic measure for the frazzled nerves and flat feet of nursing department employees. Of course, depart-

ment heads and other key people in the hospital where an addition is being planned should be called in to comment on the proposed program and the plans as they are developed.—E. W. JONES.

Medical Director Needed?

Question: The board of trustees of this hospital is interested in knowing if it should continue the position of medical director in addition to that of administrator. The hospital is a 200 bed general, nonteaching institution without either interns or residents.

Would the position of medical director be in conflict with the duties of the chief of staff? Do you believe a member of the medical staff could fulfill the position along with carrying on his private practice? What would be the duties of a medical director if one were indicated?—A.O., Ohio.

ANSWER: It is common practice in many hospitals to have a medical director in addition to the chief executive officer or administrator. However, it is important to make certain that there is no misunderstanding as to authority and responsibility in the organization. Many hospitals prefer to use the title of administrator and, in cases where a medical man is on the administrative staff, call him the assistant administrator rather than medical director. However, because of local conditions, the title of medical director may be essential.

In a hospital the size of yours, it is questionable whether there is need for a full-time medical director. Certainly, if the chief administrative officer is a doctor, there should be no need for a second doctor on the executive staff. If, on the other hand, the administrator is a layman, it might be advisable to appoint one of your staff members who has displayed administrative and teaching ability as assistant administrator and medical director on a part-time basis.—E. W. JONES.

Paint for Metal Surfaces

Question: Is an aluminum paint the best type of sealer to put directly on metal surfaces, such as iron or steel?—M.W., Wash.

ANSWER: No. The best type of paint to put directly on such surfaces is a rust inhibitor such as red lead paint. However, it is wise to put a coat of aluminum paint over the red lead as a seal against moisture. The final or color coat can then be put on over the aluminum.—E. W. JONES.

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Ala.; William B. Sweeney, Wind-
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Fisher, Thayer Hospital, Waterville,
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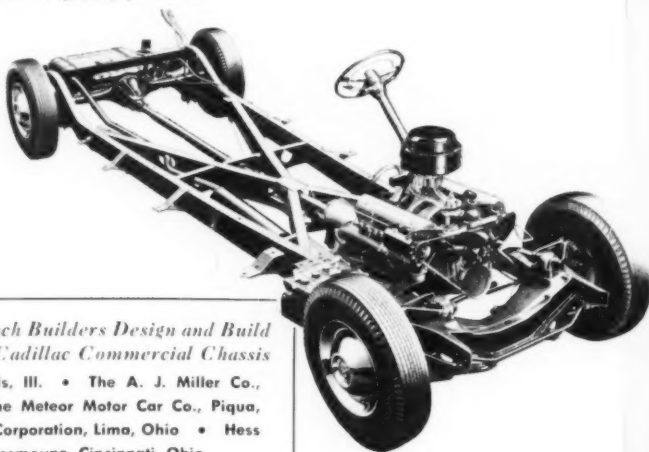


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Looking Forward

Only Thing Matter

WE WERE out when our friend Anastasia stopped at the office the other day, and it has taken us some time to piece together the notes she left for us. Now that we have decoded the greater part of these, however, we find Anastasia's highly individualized logic working at top speed.

"Have great idea for Truman, Ewing &c," Anastasia wrote. "In order stay alive so can get sick, get benefits socialized medicine, man must eat, dress. Obvious need for socialized soup and fish. Both kinds.

"My plan works same way Ewing's," Anastasia went on. "Small pay roll tax, balance out of general funds. Free choice waiters, tailors. Everything same except method payment." There were some more notes here that we couldn't make out, then a final scrawl: "Anything matter this plan?"

We may be out again when Anastasia calls, so we've left an answering note for her. "Only thing matter your plan same as Ewing's," this says. "Not enough waiters, tailors, money. Won't work."

The Power and the Duty

A BILL now being studied by committees of the New York State legislature would make it unlawful for any hospital supported wholly or partly by public funds to refuse to permit any licensed physician or surgeon to diagnose, treat or operate on any patient in any such hospital. The bill would also make it unlawful for the hospital to refuse admission to any patient sent by a licensed physician or surgeon. Since all voluntary hospitals receive some public support in the form of tax

exemption, passage of this legislation would drastically alter existing concepts of hospital responsibilities.

The widely accepted view today is that the hospital's obligation to its patients and its community includes responsibility for the quality of medical care rendered within its walls. By careful selection of medical staff members and insistence that proper staff rules governing supervision of medical practice be written and followed, the hospital board does all that can be done to protect its patients. In exercising its authority in these areas, the board necessarily acts on advice of staff committees in nearly all cases; thus, few physicians see these regulations as an infringement on their professional freedom.

The hospital's right to restrict practice to acceptable physicians is recognized by the highest legal and medical authorities. "There can be no absolute right in individuals to claim the benefit of [hospital] privileges," the court of appeals of New York State held recently, ". . . nor do we deem it illegal discrimination if from a large number of physicians it selects members of its visiting staff with regard not only to their medical skill but to their adaptability to the rules and discipline of the institution."

Physicians who do regard restrictive action by hospital boards as "lay interference" may be surprised to learn that such action has long been upheld by the Judicial Council of the American Medical Association. "The board of control of any hospital (not maintained by general taxation)," the council ruled some years ago, "has the legal right for reasons sufficient to the board to refuse the privileges of the hospital at any time to any practitioner regardless of his so-called school of practice. The fact that the person applying for permission to bring to and treat in the hospital a particular patient is

licensed by the state to practice does not alter the situation."

Fortunately, the bill that has now been introduced in New York State has little or no chance of becoming law. However, consideration of the problems it raises and the evils which could be expected to follow its passage should strengthen the resolve of hospital administrators and board members to use the authority they have to guard the safety of hospital patients.

Hospitals Are Different

WHATEVER amendments may ultimately be made to the Taft-Hartley Act, or whatever legislation may be substituted for the act if it is repealed, it is important that the exemption of hospitals from provisions of a federal labor-management law be continued. This is not to say that hospitals should not bargain collectively with unions representing hospital employees; as a matter of fact, there is now abundant evidence that hospitals and unions can live together amicably and work together advantageously through collective bargaining.

To make union recognition and collective bargaining mandatory on hospitals as on industry under the law, however, would be to risk possible hardship or hazard to hospital patients. The hospital has no profits to bargain with; the money that is paid to employees in wages must be collected from sick patients in fees. Unless hospitals are exempt from mandatory bargaining, hospital management loses its power to protect patients against unreasonable or excessive wage demands by labor. Unlike the customer of industry, the hospital patient cannot protect himself against such demands by refusing to buy.

The unquestioned fact that some hospitals still pay unreasonably low wages and have archaic views on labor's rights generally must not be permitted to obscure the more important fact that hospitals are set apart from industry by their nonprofit structure and their function of caring for the sick. That hospitals are so set apart in the public mind has been demonstrated time after time when public opinion has bitterly opposed hospital strikes—even in communities known to be strongly pro-labor in sentiment. The law should certainly support a distinction that is obviously accepted by the public.

Granted exemption from labor-management laws and special consideration in public opinion, the moral pressure on hospitals to pay adequate wages and deal fairly with employees is correspondingly greater than the pressure in industry. The hospital that is keeping rates down by imposing on workers is on the same moral plane as the union that demands excessive wage increases at the expense of patients. In the care of the sick, there is no place for cupidity on either side.

Keep the Intern Plan

AS HOSPITAL and medical school executives freely acknowledge, the rules governing notification and acceptance of internship appointments have not been uniformly successful. Admittedly, some hospitals are

jumping the gun and attempting to close their appointments in advance of the stated deadline. Some are demanding an immediate yes or no answer from appointees instead of permitting them the reasonable waiting period called for in the rules.

Violations by hospitals make violations by the respondent interns unavoidable, and under-the-table agreements are frequent. Knowing that such departures from the rules are taking place, many hospital people think the whole internship plan should be abandoned. It isn't working, they argue, so why keep it going?

While one can sympathize with the plight of hospitals that aren't getting any interns, it is hard to see how abandoning the plan would help them. As a matter of fact, it seems likely that a return to the old, every-man-for-himself system would simply add to the number of hospitals left in the lurch.

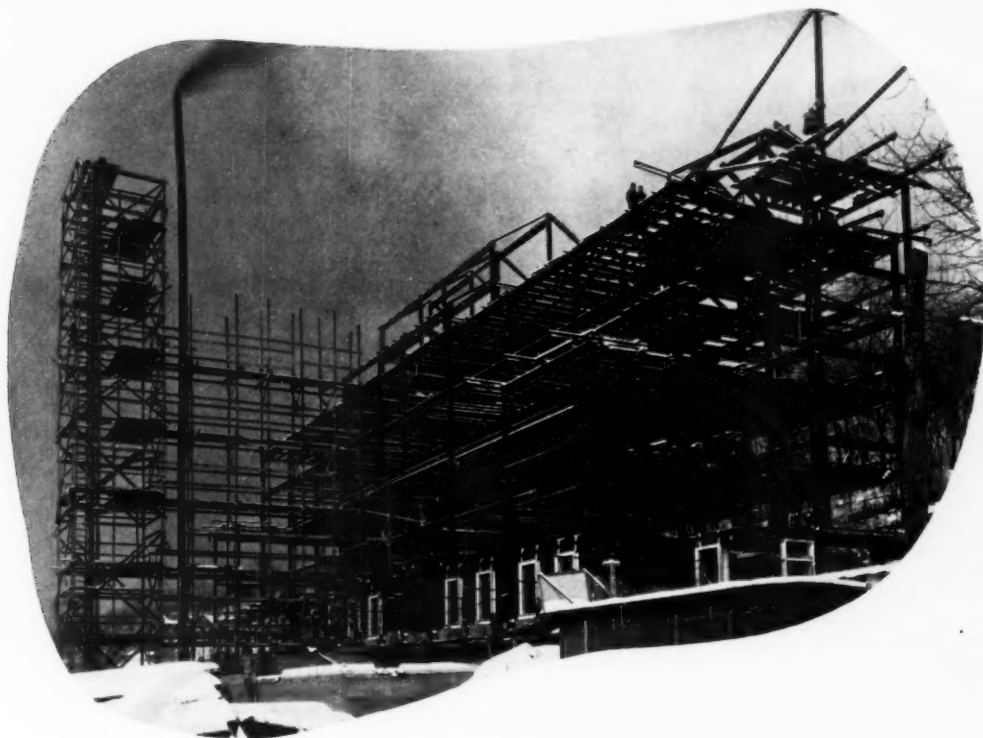
As Dr. Buerki pointed out at Atlantic City last September, and as he reasoned again during the discussion of internships that took place at the recent congress on medical education and licensure, the trouble is not in the plan but in the fact that there are nearly twice as many internships as there are interns. Under the difficulties imposed by this central fact, the present plan is as equitable as any plan could be; until somebody proposes a better one, it would be a mistake to give it up. Half a loaf is better than no interns.

Job Study Job

FEDERAL bureaus, it was reported recently, usually have one personnel officer for every seventy-five to 100 employees. This would seem to be ample for the normal personnel functions of hiring, firing, grading and general tab-keeping. If there are any personnel experts with time on their hands in the army, navy, Veterans Administration or Public Health Service, they might turn to and make a thorough job analysis of executive positions in the medical departments of those bureaus, with a view to making possible the better utilization of medical manpower.

Such a study would almost certainly reveal medically trained executives in many positions requiring no real medical functions. Replacement of medical with lay administrators in all such positions would release that many physicians for clinical and truly medical administrative responsibilities, with consequent improvement of the whole federal medical economy. Policy-making administrators whose decisions may occasionally involve medical judgment do not need to be physicians if an adequate medical advisory service is available, as the satisfactory operation of the insurance, pharmaceutical and other industries under lay executives amply demonstrates.

Similarly, job studies might be made in the federal nursing services, looking toward the release of nurses for strictly nursing duties. In the army and navy, for example, Wacs and Waves might well replace graduate nurses now doing clerical or administrative work, so that these specially trained women could be used for the kind of work they were trained to do.



BUILDING PROBLEMS TODAY

THE BUILDER'S VIEW

George F. Hutter

THE SPECIAL FACILITY

Frank Latenser

THE SMALL HOSPITAL

Alfred L. Aydelott

ADDITION AND REMODELING

William A. Riley

THE LARGE HOSPITAL

Valdemar H. Paulsen

RADIANT HEATING

John K. M. Pryke

DENTAL SERVICE UNIT

James S. Miller and J. R. McGibony

According to

The Man Who Builds Them

hospitals are getting better

LIVE your job!" is the admonition to hospital planners and builders of a man who has been building hospitals for fifty years and has plainly lived every one of them. To the visitor in his office, the pictures that ring the walls are so many buildings on so many plots of ground, but to George F. Hutter they are everlasting experiences, each with its individual trials and triumphs.

Now president of the Hutter Construction Company at Fond du Lac, Wis., George Hutter has been building hospitals, almost literally, since he was a boy in knee pants. The business was founded in 1848 by Joseph Hutter; the fresh, brown earth of an excavation and the smell of new lumber were familiar to young George before he could say "specification." He became a partner in the family business at about the time he started to shave and has been building ever since.

Unlike many men who have been in the same business for years, however, Hutter never yearns for the good old

days. On the contrary, he thinks these are the best days we've ever had, as far as hospital building is concerned. "Every hospital that's built today has many features that are better than anything we had twenty years ago," he said recently. As a result, he thinks, today's hospitals will last longer and give better service. What's more, they'll be economical to operate. For example, he points out, "We used to plaster all the interiors walls—corridors and operating rooms as well as patients' rooms. Then in a short time we were back again, putting in new plaster where carts had banged against the walls or constant moisture had taken its toll. Today we put in wainscotings of tile or other impervious material wherever a wall is going to take a beating. It costs more to begin with, but all the expense of constant replastering is avoided, and eventually the hospital saves money."

For the new hospital, Hutter believes, economy should really begin at the earliest point in planning—the

selection of an appropriate site. In more cases than is necessary the building committee, board of trustees, or other responsible group confronts the architect and builder with a problem that has already been made difficult because the site is not suitable for hospital purposes. "Of course," Hutter acknowledged, "in many instances the site is a gift to the hospital association, church order or government body that is going to build, and nothing could have been done about it anyway. But in other cases that isn't true, and lots of unnecessary expense and delay can be saved by consulting an experienced architect or consultant about the site."

Subsoil structure, slope, drainage, water supply, and many other features of a proposed site must all be studied carefully in relation to the building that is to be built there, Hutter explained. Then all these considerations must be matched with the suitability of the location from the standpoint of its accessibility to staff, patients and personnel. "These things may sound



Aerial view of St. Francis Hospital, Wichita, Kan., showing construction of "Building E" and addition.



Temporary passage connecting hospital, laundry and nurses' home during a hospital building project.



GEORGE F. HUTTER

obvious and elementary," he said, "but you'd be surprised at the number of hospitals we have to build in poor locations only because someone thought the view would be beautiful!"

Above all, Hutter warned, hospital groups should be sure that the site is ample to permit future expansion. Tomorrow's needs are always going to be greater than today's, and eventually most hospitals must be enlarged, he has found out. No problem is tougher than the addition that must be planned and built within the limitations imposed by an inadequate site. Here, again, lasting expense may be involved; the plan that has to meet severe site obstacles is rarely the plan that is most economical to operate.

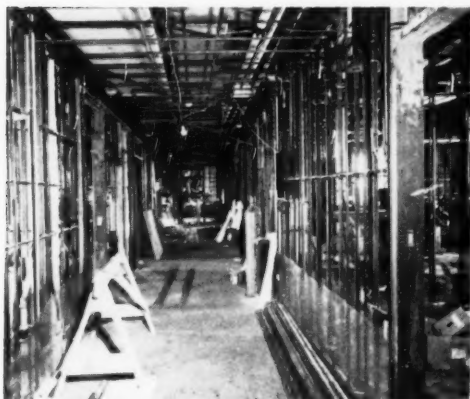
Adequate allowance for later expansion should be one of the fundamental considerations at every step in hospital planning, according to Hutter, who has built many hospitals that started small and finished big. For example, if you plan space for two boilers when one is enough today, or for three when you need only two, it will be a long time before you need to build a new power plant. The same principle can be applied to advantage in planning the kitchen, laundry, storage space, and other service facilities, Hutter believes. "We build new power plants and laundries for hospitals right along," he said, stating a fact that gives the point considerable emphasis.

Obviously, the entire hospital plan should also contemplate possible later expansion. All too frequently, for example, stairways are located at the end of a corridor and must be removed if the corridor is extended to add patients' rooms. Not only is this a waste of time and materials, but it means that the stairs must go back in some place else—often as not at a considerable sacrifice of convenience and economy.

In line with his "live the job" philosophy, Hutter agrees with the recently expressed view that everyone who plans hospitals should put on an orderly's uniform and work on a hospital floor for a few weeks. He has never actually done this himself, but the hundreds of hours he has spent walking the corridors of his hospitals add up to the same thing. As a result, his hospitals feature many little devices that save steps or add extra comfort for

patients. Built-in cabinets for particular uses are a Hutter specialty, for example. It isn't always possible or desirable to standardize this kind of facility, Hutter explained; the doctors and nurses or Sisters in one hospital may like to do things a little differently from those in another. One such device that everybody likes, however, is a built-in bedpan warmer which he worked out with an administrator for whom he has built several hospitals. This is a single coil of hot water pipe that runs through a compartment in the lower part of a locker in the patient's room, connected to the domestic hot water supply. The coil is shaped to hold a bedpan and keep it at body temperature—saving the time it takes to warm it for each individual use and insuring the patient against the discomfort that results when chill metal meets warm flesh.

The fact that he has been called back time after time to build hospitals for the same Catholic orders demonstrates that these and other features are standing the test of time and use. Happily, most architects welcome the breadth of experience Hutter brings to their jobs. Ideally, the architect and a building consultant should work together as a team, Hutter believes, starting with the beginning stages of planning. In addition to the aid he may furnish in site selection, there are some ways in which the building consultant may be able to help even the most experienced architect. As an example, Hutter pointed out that it is his job to be familiar with up-to-date market conditions in all types of building materials



BEFORE: This maze of pipes was a corridor in St. Francis Hospital before the plaster had been applied.



AFTER: Plaster and tile make such a difference in the appearance of the same corridor (maternity).



Left: The bedpan warmer installed in the bottom compartment of a locker is a popular item. Right: Rear stair tower, St. John's Hospital, Tulsa, Okla.



in all parts of the country. "An architect's plan might call for a certain kind of tile to be delivered on a job in Butte, Montana, for an installation that's scheduled to begin in March, let's say," he explained, "and I may know that we're going to have trouble getting it there at that time. If the architect and I are working together closely in the planning stage, I can pass this kind of information over to him as we go along. Otherwise, it's likely to pop up as one of those nasty 'substitution' problems after the job is started or well under way."

The very word "substitute," as a matter of fact, is abhorred by Hutter and other contractors. "The word is almost universally associated with something inferior," he said a few months ago in a talk on building material problems. "Actually, whenever there is a choice of more than one material, the selection of one is no reflection on the other." He went on to stress the importance of early and continued cooperation among owner, architect and builder. "The contractor does more than mix and pour concrete, lay brick, cut and nail lumber," he declared, elaborating on a favorite theme. "He is also the assembler of many premanufactured items, and all too frequently it is the premanufactured items that retard progress and delay completion of the job. Often, the contractor is in a position to recommend or suggest the use of materials that he knows are in plentiful supply."

If he is a partner with the architect on the one hand, the contractor is also partners with the building material manufacturer or processor on the other, as Hutter sees it. "The builder

needs the manufacturer and the manufacturer needs the builder," he said on the occasion of his recent talk. "Each has his duties and responsibilities. The builder must determine and order his materials in time to permit the manufacturer to fit them into his schedule; he must give accurate information and details, and promptly check and return all shop drawings, if they are necessary. To ease the warehousing problem for the manufacturer, the contractor should be prepared to accept delivery of cement and premanufactured items, such as millwork, metal cabinetry, and hardware, as soon as the manufacturer is ready to ship."

"The manufacturer's responsibility, on the other hand, is to make delivery on schedule and to trace and expedite shipments after they are made to eliminate or reduce to a minimum any delays in transit. If a harmonious relationship can be maintained between the two, it follows that inestimable benefits will accrue to the owners of buildings in process of erection."

With hospitals going up simultaneously in several different parts of the country today, Hutter and his associates, including his son, George Jr., who entered the business a few years ago following graduation from the University of Michigan, are busier than they have ever been before. Under these circumstances, it is understandable that they look with favor on Public Law 725, through which some of their hospitals have been financed. That it has thus been good for business is not by any means the only reason the Hutters are favorably inclined toward the law, however. The fact that it is getting hospitals built where hospitals are needed is its chief virtue, in their opinion, and they also see the regulations governing design and quality of materials as safeguards against poor building and consequent unnecessary maintenance and operating costs.

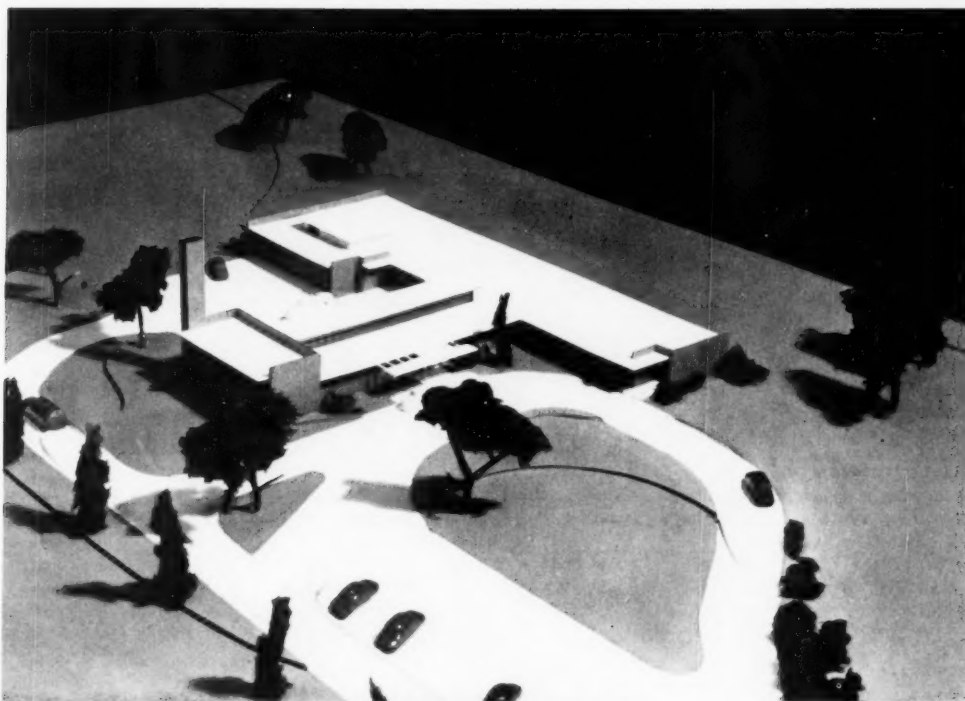
Easier financing, better planning, and continued improvement in the applications of materials should give the nation more and better hospital care in the years to come, Hutter is

convinced. Asked about the possible advent of "miracle materials" that will bring uses and economies unheard of today, he is frankly skeptical. As he views it, the miracle materials hospital planners and builders should be concerned about are those that are here already.

"There has been a spectacular procession of improved materials and equipment for buildings of all kinds," he pointed out. "We have prefinished flooring, an endless variety of new, functional wall and ceiling materials, insulating and acoustical materials, simplified hardware, improved plumbing and heating assembly design, adhesives, better paint ingredients, doors ready to hang. We have new kinds of cement. We have brick and other structural clay products in modular dimensions, permitting adaptability to a wide range of vertical or horizontal dimensions without wasteful cutting or wasting of the masonry units. We have glass block and double widow insulation. We have glazed structural tile that requires no further finishing as wall surface, and we have developments in heating which assure the availability of systems of high operating efficiency for any and every size of building."

"Let's make the best possible use of these and all the other miracle materials that are at our disposal now," he concluded. "If we all work together and live our jobs the way we should, tomorrow's hospitals will be as much better than today's as today's are better than those we built fifty years ago."

Hutter looked around at some of the hospital pictures in his office. "Come to think of it," he added, "even those weren't so bad."



ARCHITECT'S MODEL, NORTH SUNFLOWER COUNTY HOSPITAL, RULEVILLE, MISS.

The SMALL HOSPITAL OF THE FUTURE

turns up today in Mississippi

ALFRED L. AYDELOTT

Dent and Aydelott
Robert Moor
Architects
Memphis, Tenn.

NORTH Sunflower County Hospital, Ruleville, Miss., was designed to serve a population of approximately 35,000, 60 per cent of which is colored. Segregation in the patients' block is required. Per capita income is \$750. There are ten practicing physicians in the county, most of whom reside in Ruleville—population about 1500.

The site encompasses about 10 acres of flat ground near the junction of two main highways.

Patients' rooms are all designed for private or semiprivate use, with a possible census of between eighteen and thirty beds. Colored patients will be assigned one end of the patients' block, space being utilized in accord with demand.

Following is a breakdown of the various areas of the hospital.

ADMINISTRATIVE DEPARTMENT:

This unit includes main lobby with two waiting rooms and four public toilets; a business office with space for director of nurses (also administrator) and record room; staff lounge with toilet.

ADJUNCT FACILITIES:

A laboratory and adjoining radiographic suite complete with toilet, darkroom and dressing space will be in charge of a technician, with office space in the laboratory.

NURSING DEPARTMENT:

Consists of one unit of eighteen to thirty beds, including one isolation suite, with two each of utility, bath, toilet, janitor and bedpan facilities.

NURSERY:

This area contains two nurseries of six bassinets (white infants) and four bassinets (colored infants). Formulas are prepared in the kitchen.

HOUSEKEEPING:

This department includes laundry, linen repairs, linen issue and storage.

SURGICAL AND OBSTETRICAL:

These two departments are grouped around the central sterilizing workroom but with complete separation from each other. One room each for major surgery, minor surgery, delivery, labor, nurses' and doctors' lockers. Each department to have scrubup facilities, clean up rooms, janitor's closet and supply closet. Delivery to have sub-sterilizer. Minor surgery room at ambulance entrance.



STORAGE DEPARTMENT:

Central storeroom in service wing.

DIETARY DEPARTMENT:

Includes main kitchen, day storeroom, formula and diet facilities, dish-

washing room, and refrigeration. Dining space for the staff.

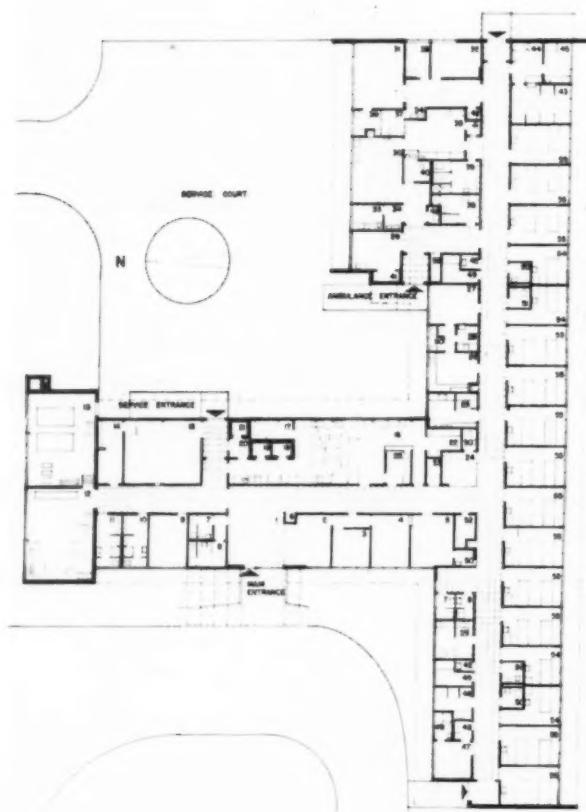
MECHANICAL FACILITIES:

Boiler and pump room sufficient to include hot water storage, maintenance

shop, toilet and emergency lighting equipment. Fuel is natural gas.

EMPLOYEES' FACILITIES:

Locker room with toilet and shower for both male and female employees.



NORTH SUNFLOWER COUNTY HOSPITAL

DENT & AYDELOTT

ROBERT MOOR

ARCHITECTS

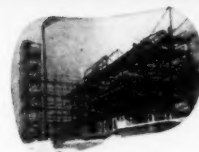
LEGEND

1. LOBBY
2. OFFICE
3. SUPERINTENDENT OF NURSES
4. RECORDS
5. STAFF LOUNGE
6. TELEPHONE
7. MEN
8. WOMEN
9. STAFF LOCKERS
10. WOMEN'S LOCKERS
11. MEN'S LOCKERS
12. LAUNDRY
13. BOILER
14. REPAIR SHOP
15. STORAGE
16. KITCHEN
17. DAY STOREROOM
18. MEAT REFRIGERATOR
19. VEGETABLE & DAIRY REFRIGERATOR
20. CAR WASH
21. BARBERS
22. FORMULA
23. DSH WASH
24. NURSE'S STATION
25. UTILITY
26. LABORATORY
27. X-RAY
28. DARK ROOM
29. MINOR SURGERY
30. MAJOR SURGERY
31. DELIVERY
32. LABOR
33. CLEAN UP
34. SCRAP UP
35. CENTRAL STERILIZATION
36. SUB-STERILIZATION
37. STERILIZED ALCOVE
38. DRESSING LOCKERS
39. NURSE'S LOCKERS
40. AIR CONDITIONING MACHINE ROOM
41. STORE
42. JANITOR'S CLOSET
43. NURSERY
44. NURSE'S WORK
45. SUSPECT NURSERY
46. COLORED NURSERY
47. ISOLATION
48. ISOLATION UTILITY
49. BATH
50. TOILET
51. BED PAN
52. PHARMACEUTICAL STORES
53. STRETCHER
54. PRIVATE ROOM
55. PRIVATE OR SEMI-PRIVATE ROOM

SCALE 0 5 10 20 25

VETERANS' HOSPITAL

combines functional efficiency with esthetic appeal



A MODERN hospital for veterans is now being constructed in Newark, N.J., providing 1000 beds for the veterans of that state and will incorporate in its modern structure the latest facilities and equipment that are known in the science of medical treatment. Also under construction on this 35 acre site are separate service buildings for power plant, garage, laundry and mechanical shops. These structures will cost about \$17,000,000. Contracts are still to be let for a doctors' residence, nurses' residence, attendants' residence, staff house, and complete development of the site, all of which will cost approximately \$1,000,000.

NEED FOR HOSPITAL

An idea of the potential hospital load in New Jersey can be gathered from the following facts:

Six hundred applications for hospitalization are filed monthly at the Newark regional office of the Veterans Administration, of which 450 are considered legally and medically eligible for admittance to a Veterans Administration general medical and surgical facility.

Sixty-nine thousand veterans in New Jersey have service-connected disabilities.

Congress has also specified to the Veterans Administration that veterans with nonservice-connected disabilities may be hospitalized when a suitable bed is available and the veteran is unable to defray expenses. There are

approximately 600,000 veterans in New Jersey with no service-connected disability.

During the fiscal year ending June 30, 1948, the following number of veterans were examined and treated in the state of New Jersey as medical and surgical patients on both a staff and fee basis:

Eighty-five thousand veterans received treatments and to this group 257,000 treatments were given.

Sixty-eight thousand veterans were examined for pension and other purposes and to this group 132,000 examinations were given.

Twenty-five thousand dental examinations were performed and 25,000 dental treatments were given.

Lyons is the only Veterans Administration hospital now existing in New Jersey and provides treatment in psychiatry. Owing to the lack of adequate facilities within the state, many New Jersey veterans are hospitalized in Veterans Administration hospitals in New York, Pennsylvania and Delaware.

THE PROGRAM

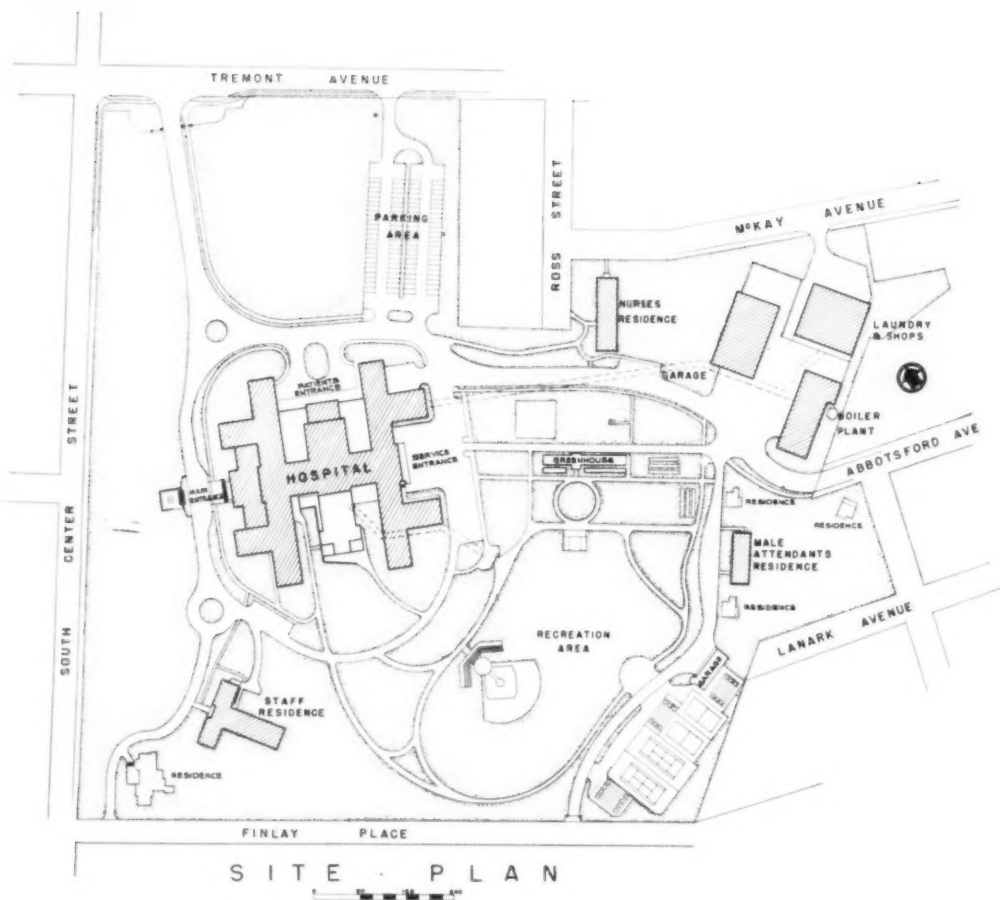
This hospital group, whose construction is under the direction of Col. W. W. Wanamaker, District Engineer, New York District, Corps of Engineers, U.S. Army, is a unit of the

Veterans Administration nationwide hospital building program, the largest and most comprehensive hospital building program in history. The requirements for this vast program were prepared by the Veterans Administration and the responsibility for coordinating this gigantic task was assigned to the Corps of Engineers, Department of the Army.

This program cautioned architects that in the design and planning of a veterans' hospital consideration must be given to the fact that the operation and function, both professional and administrative, differ greatly from civilian hospitals for the following reasons:

1. Average length of veterans' hospitalization is considerably greater than in acute civilian hospitals.
2. Fifty per cent of patients are ambulatory.
3. Because of pension status of most patients admitted, special facilities must be provided for conducting physical examinations, preparation of reports, and transmittal of pertinent data to adjudicating agencies.
4. Space for additional agencies and service offices is required.
5. Only 2 per cent of patients will be female, and no obstetrical cases will be admitted.





Required bed capacity will comprise the following:

	Units	Beds
Standard nursing units of		
40 beds	17	680
Neurological units	2	80
Neurosis units	2	80
Psychiatric units	3	120
Psychiatric isolation unit	1	4
Women's unit	1	20
Isolation unit	1	20

THE SOLUTION

The General Scheme.

In the early schematic stages of planning it was decided to use the simple H form of building. This form was selected after a careful study of the functional layout of a typical forty-bed nursing unit and of forms best adapted to house the numerous other hospital facilities. This H form per-

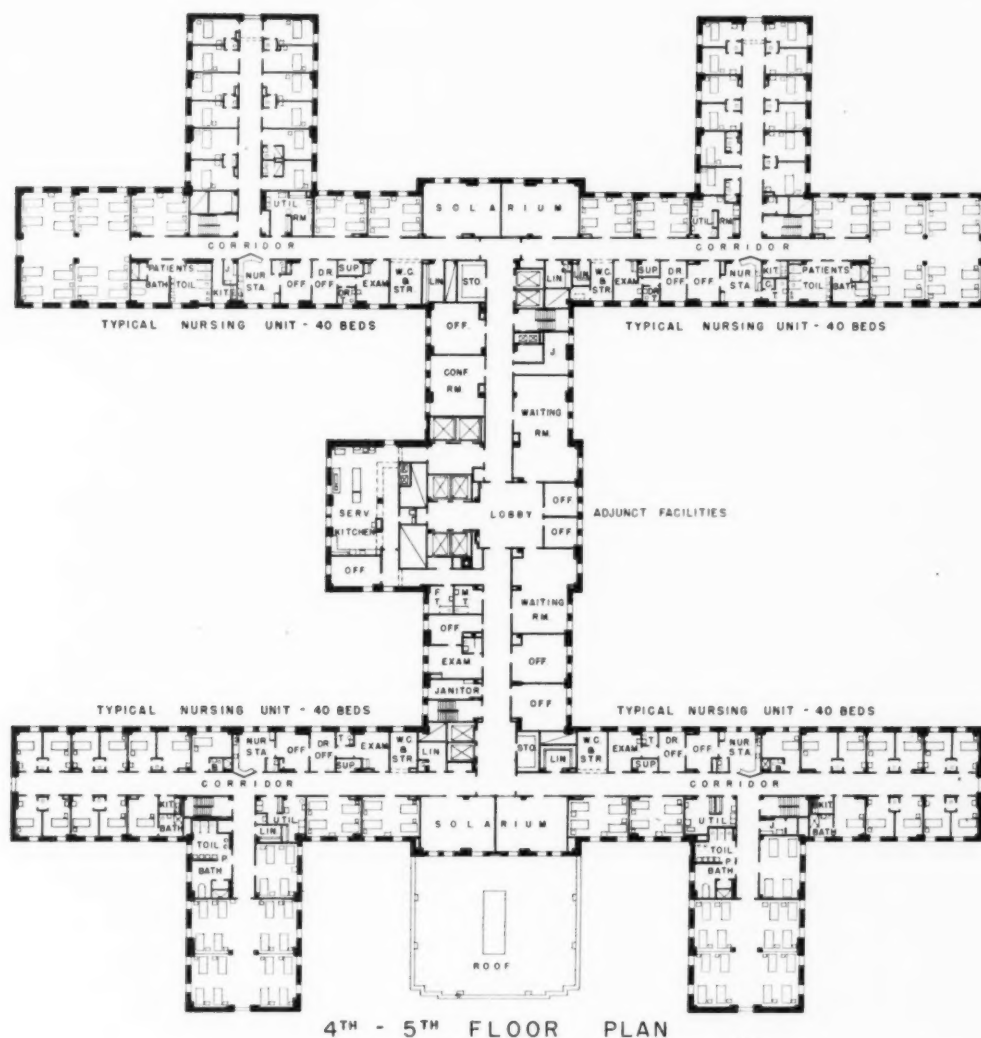
mitted a grouping of each distinct functional service in a cul-de-sac which would be free of cross traffic.

The level east portion of the site was selected for location of utility buildings and service road, and the center portion of the site, also level, was selected for passive recreation of the patients. The western portion has a sharp rise in elevation from the surrounding areas and bordering streets and was selected for location of the main hospital building and a private road leading to main public and patients' entrance and parking areas. The building will rise thirteen stories in the west or front wing and sixteen stories in the east or rear wing and will be located 250 feet back from the front property line. The east and west wings will be 370 feet long and the cross wing, 370 feet deep.

All the nursing units are housed in

the upper floors of the east and west wings. The cross wing houses all public and staff elevators and dumbwaiters and all general services for nursing units, such as serving kitchens, general offices, conference rooms, visitors' rooms. All general horizontal travel on each patient floor is restricted to this cross wing and travel in the patients' east and west wing is restricted to that which is directly involved with patients' care.

In adjusting to the topography of the ground, three separate grade entrances on three different floor levels were provided, resulting in a desirable segregation of traffic; the main public entrance is on the front or west side of the first floor; the outpatient and emergency entrance, on the north side of the floor below, and the service entrance, on the east side two floors below first floor.



4TH - 5TH FLOOR PLAN

VETERANS ADMINISTRATION HOSPITAL
NEWARK NEW JERSEY

Nursing Units.

Six hundred and ninety-two general medical and surgical patients and 265 neuropsychiatric patients are located on the second and fourth to thirteenth floors, inclusive.

Each standard nursing unit of forty beds has been so planned as to reduce to a minimum the distance to be traversed to the farthest patient's bed from the nurses' station and patients' nursing facilities, and also to provide visual observation and control of all patients' corridors. In this day of doctor and

nurse shortage such a planning feature is mandatory.

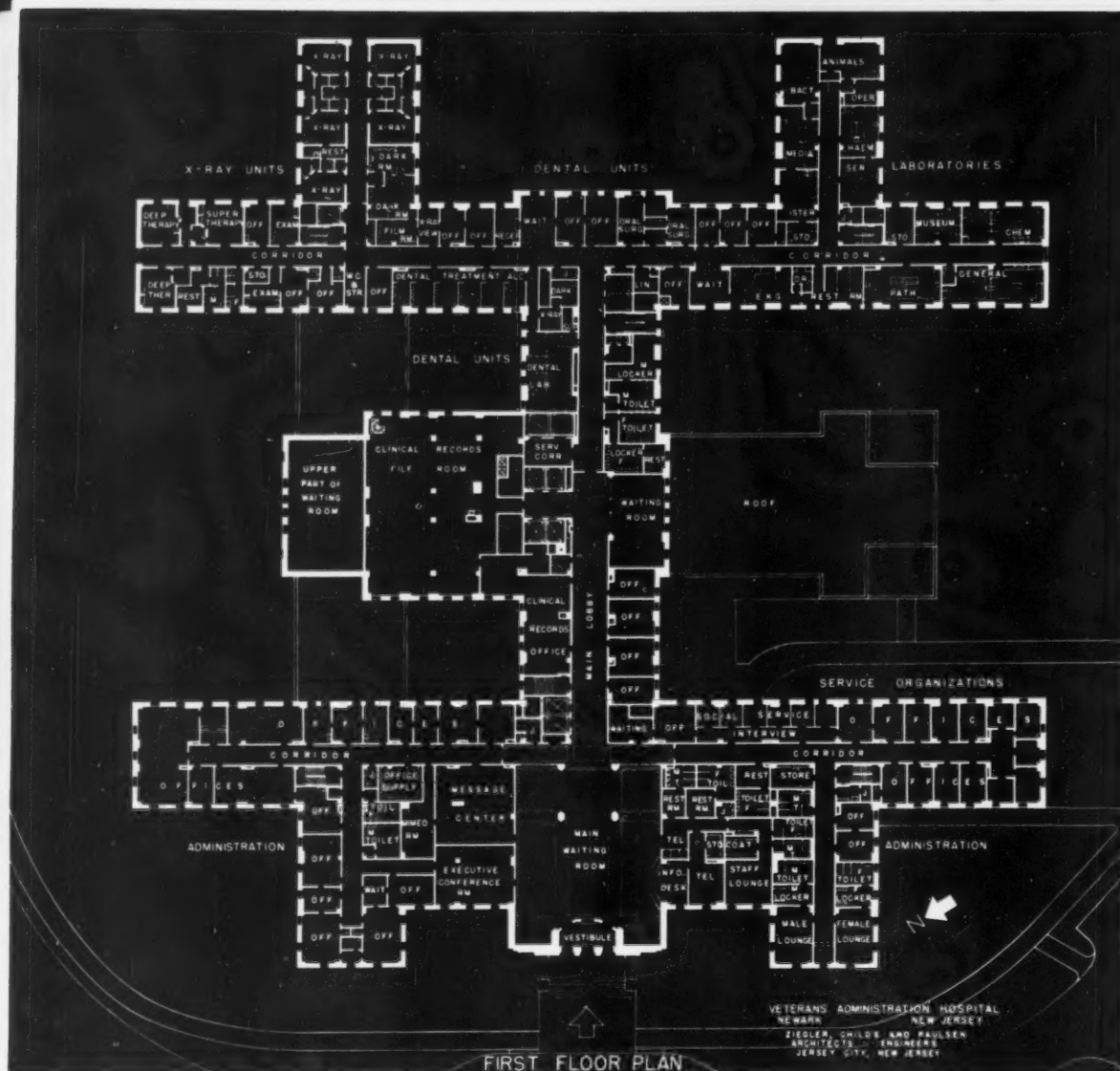
In order to accomplish this, the nurses' station has been placed at the hub or intersection of three corridors, one corridor end housing four and sixteen bed wards, the second corridor end housing single bed rooms, and the third corridor housing treatment and examination rooms, doctors' office, visitors' waiting room, and so forth.

Neuropsychiatric Service.

This service is located on the top

four floors of the hospital, thereby providing a degree of privacy, and contains a neurological and a neurosis unit of eighty beds each and a psychiatric unit of sixty beds for the quiet section and forty-five beds for the disturbed section. Recent developments in the care of this type of patient have materially affected the planning of these units.

Most of these patients are ambulatory and the daytime activity areas are distinctly separated from the sleeping section. The nurses' station affords a



direct view of a large airy dayroom which in turn opens directly onto a protected sun deck and also affords control of the corridor leading to the bed areas.

A hydrotherapy department is centrally located on the same floor as the disturbed patients, with direct access provided for these patients and a separate entrance provided for all other patients. This service has been provided with many other special features, such as additional offices for consultation and interview of patients by psychiatrists and psychologists; shock treatment rooms; a well shielded elec-

troencephalographic unit; small seclusion and isolation sections; visitors' rooms, and dining rooms for each patients' unit.

General Hospital Facilities.

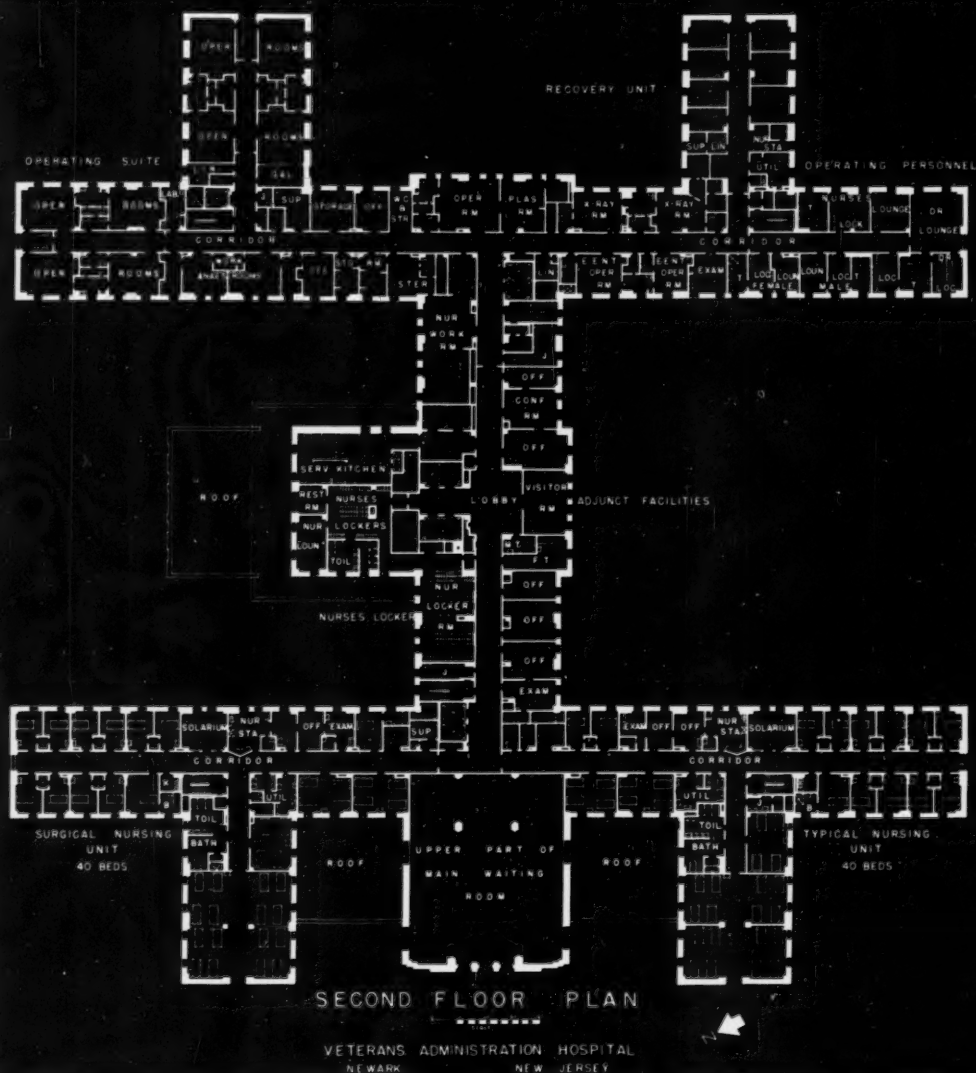
On the lower floors of the hospital are all general medical, surgical and administration functional services, such as x-ray, surgical, dental, laboratories, occupational and physical therapy, emergency and admitting departments, storage and food service, staff dining room, and patients' dining rooms. Here, also, are recreational, educational and religious facilities and a post office and canteen.

Structure.

The hospital will be totally fireproof with a structural steel frame and concrete floors and masonry partitions. The exterior design will be modern in character with plain wall surfaces accenting a vertical treatment. Exterior walls will be constructed of a light colored brick with block backing and with granite and limestone on lower stories as trim.

Personnel.

Approximately 1100 employees will be required to man this hospital. Operating personnel will possibly include forty-three full-time physicians, eleven



dentists, 161 nurses, 307 attendants, and a part-time medical staff.

Mechanical.

Four passenger elevators are provided for public use, four for patients and staff, and two for service. These are all standard sized cars with a speed of 700 feet per minute. Two electric dumbwaiters carry special diets and two carry medical supplies.

The entire project will be heated by steam from the central power plant. Convactor radiators will be used except for the operating and psychiatric sections where panel heat will be provided.

The operating, x-ray and laboratory suites and ten allergy rooms will be air conditioned.

A pneumatic tube system connects the medical record room with all nursing stations, treatment sections, and record offices.

A four-channel radio system is provided with outlets at each patient's bed. This system is equipped with plugged-in listening devices and selector and is connected with a broadcasting studio which is located in the hospital building.

Other systems installed are: doctors' paging, nurses' call, special alarm for neuropsychiatric nursing units, telecart

system for bedridden patients, and suction and compressed air.

CONCLUSION

While solving the many problems involved in interpreting and incorporating all the general and special requirements of the criteria, emphasis was placed on the development of a truly contemporary hospital plan having utmost functional efficiency and also on the importance of an exterior mass having esthetic appeal.

Important factors affecting planning were consideration of economy of construction, durability of materials, and ease of maintenance and operation.



PSYCHIATRIC UNIT *is a credit to the community*

FRANK LATENSER

John Latenser and Sons, Architects-Engineers, Omaha, Neb.

MODERN medical practice, as well as moral and religious obligations in the care of the mentally ill, will receive full recognition in the splendid new edifice which is being erected as a specialized unit of the Creighton Memorial St. Joseph's Hospital, Omaha, Neb.

To be known as "Our Lady of Victory Pavilion" of the present 460 bed general hospital, the new structure will provide 136 additional beds, including an open floor of thirty beds for general medical patients and neurasthenics, and 106 which will provide accommodations for the scientific treatment of psychiatric cases. Included also will be twelve beds for alcoholic patients and a variety of types of facilities for the various stages of mental illness.

Ground was broken on Sept. 17, 1948, for the new addition, which has been planned to satisfy an urgent regional need for a modern treatment hospital for private neurotic and psychotic patients. It is to be operated as an attached department of the general hospital and is designed for treatment of patients rather than for long-time custodial care.

The Poor Sisters of St. Francis, Seraph of the Perpetual Adoration, who own and conduct the institution, are pioneers in the field of specialized departmental treatment for the mentally ill, having successfully operated a psychiatric division of thirty beds in connection with St. Joseph's since 1923.

This advanced psychiatric unit has long since outgrown its present quar-

ters in medical practice and size. Plans for the development of a new building for the psychiatric department of St. Joseph's Hospital were inaugurated early in 1944 after many conferences between Sister M. Crescentia, O.S.F., R.N., and the Sisters with the medical staff and lay advisory board. The building plans reflect twenty-five years of experience in the care of psychiatric patients as well as the results of four years of intensive study, travel and research by the Sisters, the medical and operating staffs, and the architects.

The new unit will include forty-four private rooms, of which thirty-four will have private baths; eighty-two semiprivate and ten seclusion rooms. Included among the psychiatric beds

will be a special floor with accommodations for the care and treatment of twenty-four religious patients.

A complete outpatient clinic, which is to be a special feature of the new structure, will be the largest and, in fact, one of the very few in the Midwest which will be devoted exclusively to psychiatric treatment.

Distribution of beds is shown by the accompanying table.

Not included in the listing are thirty-two treatment beds in the insulin shock department and approximately twenty beds for electric shock and other procedures scattered through the treatment rooms in the various divisions. Treatment areas on all floors are flexible for the inclusion of new developments in treatment technics.

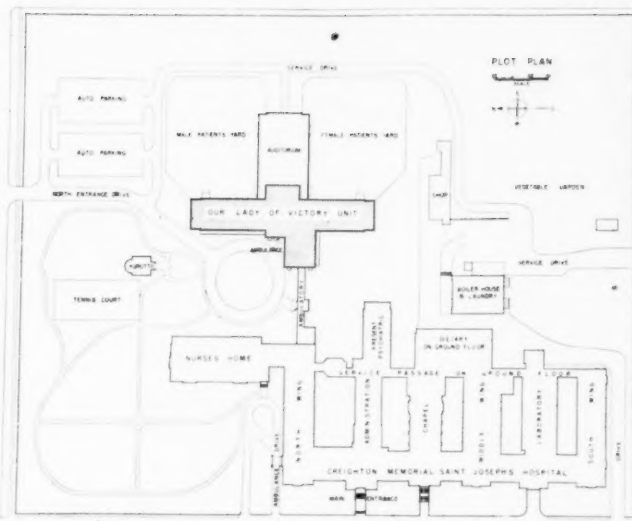
The present hospital grounds contain 13½ acres. The new unit will be located at the east of the general hospital buildings. Two open courts, 145 feet wide, will separate the main patient wings of the new unit from the general hospital. This places the new unit in the center of a beautiful wooded tract overlooking the Missouri River valley.

Separately enclosed male and female outdoor recreation areas will be provided for the psychiatric patients in this pleasant environment.

The new wing will have a cross-shaped plan with over-all dimensions of 261 by 214 feet. The main portion of the building will be six stories in height.

Because the site slopes downward to the east, one entire floor of the new unit will be below the ground floor of the present hospital. Although this lowest level is in reality a ground floor, it will be called the basement to avoid change of floor names in the existing building.

The principal entrance to the new unit will be through the main portal and foyer of the present hospital,



Above: Site plan showing how new pavilion fits in with hospital scheme. Opposite page: Architect's rendering of Our Lady of Victory Pavilion.

thence through a two-story enclosed ambulatory. The first floor will be for the use of patients and visitors; the ground floor, for the use of the dietary and service departments. There will be separate ambulance and doctors' entrances to the new wing.

FIRST FLOOR (OPEN)

Immediately at the east end of the connecting ambulatory is the administrative suite. Included are a public lobby and office, also a private office and sleeping room for the Sister superintendent. Adjoining the public lobby is a private waiting room which opens into an interview room and the psychiatrist's office. Located for easy access are the nurse supervisor's office and the doctors' lounge.

The first floor will be a thirty-bed

hospital unit, with the additional provision of a hydrotherapy department. The hydrotherapeutic equipment is arranged to serve patients from the general hospital as well as "in" and "out" patients of the psychiatric wing. There are large solariums at either end of the unit.

This floor is arranged with a nurses' station centrally located so that the north half of the floor can be used for male patients and the south half for female patients, with the usual service rooms in each section. Between the two sections and near the nurses' station is a dining room for ambulant patients. Long experience at St. Joseph's in the operation of a psychiatric unit in a general hospital led to the decision to include this open floor in the new psychiatric wing.

BED DISTRIBUTION OF OUR LADY OF VICTORY PAVILION

TYPE	LOCATION	MALE BEDS			FEMALE BEDS			TOTAL
		In Private Room	In 2 Bed Room	In Seclusion Room	In Private Room	In 2 Bed Room	In Seclusion Room	
Alcoholic.....	Ground Floor.....	4	6	2	..	..	..	12
Outpatient.....	Ground Floor.....	..	..	..	..	..	..	..
Isolation.....	Ground Floor.....	..	1	..	..	1	..	2
Open.....	First Floor.....	4	14	..	4	8	..	30
Convalescent.....	Second Floor.....	4	10	..	9	10	..	33
Disturbed.....	Third Floor.....	2	10	3	9	8	3	35
Religious.....	Fourth Floor.....	4	8	1	4	6	1	24
TOTALS.....		18	49	6	26	33	4	136

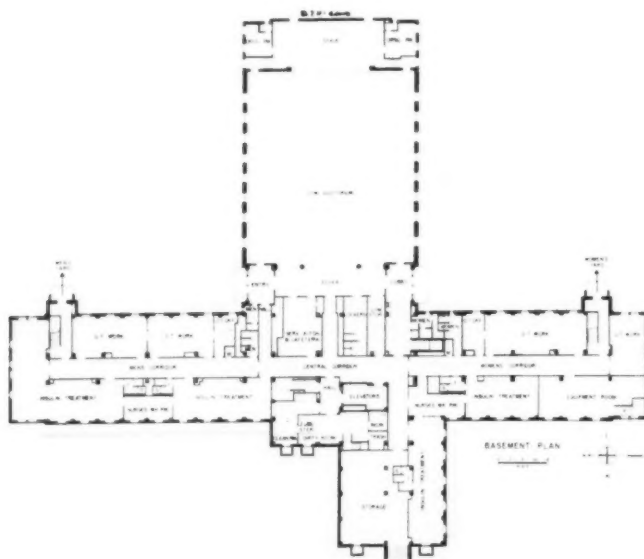


Plans on these two pages show the layout of the pavilion.

KEY TO ABBREVIATIONS

C.—Closet
Dr. Rm.—Dressing room
Fumi. Ster.—Fumigator-sterilizer
Incin.—Incinerator
L.—Linen
Lav.—Lavatory room
M.—Maid's or janitor's closet
M.C.—Medicine closet
P.—Private room
Pat.—Patients

S.—Shower
Seclus.—Seclusion
S.P.—Semiprivate or two-bed room
S.S.—Service sink
T.—Treatment
Treat. Util.—Treatment utilities, including service sink, ice bin, blanket warmer, cupboards, work table.
Ur.—Urinal
Val.—Patients' valuable safe



SECOND FLOOR (CONVALESCENT)

The second floor is planned to house sixteen male and twenty-one female convalescent patients.

The general arrangement of this floor is such that both male and female convalescent patients of the same type and treatment group, but separated as to sex, are confined on one floor and are served by a common nurses' station, treatment rooms, and dietary service.

The nurses' station will function as the control center for the entire floor and all patients' corridors are under visual control from the nurses' desks.

The nurses' station is also adjacent to the "open area" on the floor. Within this "open area" are the passenger elevator, service elevator, and the public stairway. A visitor arriving on the floor is immediately under visual control of the nurses' station and can be admitted directly to either the male or female section.

Located between the male and the female sections is the floor pantry, which is immediately accessible from the "open area." On either side of the floor pantry are the male and female dining rooms. With this arrangement, it is possible to serve both the men and women patients from one floor kitchen with tray or cafeteria service. Bulk food will be brought to the floor in electric food carts. Dishes and trays will be washed on the floor with mechanical dishwashers. The pantry and dining room arrangement will allow intermingling of the male and female patients at mealtime if desired.

The nurses' station is immediately available to the treatment department on the floor. This treatment area is located between the male and female sections and is accessible from either side. It is believed that this single treatment unit serving both the men and women will function satisfactorily if proper study is given to the timing of the treatments.

The principal advantages of this plan are:

1. All patients of similar type are under one floor supervisor and one nursing team.
2. All current medical records for similar types of patients are available at one location.
3. All patients' corridors on the floor are under visual control from one nursing station.
4. Nurses' protection alarm system records at a central point from which

assistance can quickly be sent to any location on the floor.

5. Original construction cost is less.

6. Administrative, nursing and operation costs will be considerably less than under the usual plan of having separate nurses' stations, treatment rooms, and dietary service for the male and female departments.

It is planned that all insulin treatment will be given in the basement in a specially designed department, described later in detail. Electric shock for "in" patients will be given in the treatment room on the patients' own floor. It would, therefore, be possible under the plan to use the entire treatment department at certain hours for female patients and at other hours for male patients, or to use the continuous flow tub room for male patients while the treatment and recovery sections were being used by the female patients, or vice versa. The treatment wing is complete as a functioning unit, having a service station with ice bin, utility sinks, blanket warmer, and separate rooms containing shower and toilet. Both the male and female sections have private stairs to the outdoor yard and garden, as well as to the insulin shock treatment and occupational therapy departments in the basement.

The female section contains a beauty parlor and a personal laundry; the male side, a barber shop. Bath facilities are so arranged that patients can take, or can be given, a shower or a tub bath and have their clean clothes immediately available from the patients' clothes locker room. The clothes room is also accessible from the corridor to permit an attended patient to go to his locker.

THIRD FLOOR (DISTURBED)

The general arrangement of the third floor regarding nurses' station, treatment rooms, and dietary service is similar to the second floor. In addition, each section has seclusion rooms with a private connecting corridor to the treatment department. By this arrangement a patient from seclusion is not seen by the other patients on the floor while being taken to treatment or to toilet or bath, as each group of seclusion rooms has its separate toilet and shower room for patients in this division. All of the seclusion rooms will be provided with air conditioning.

FOURTH FLOOR (RELIGIOUS)

The general plan arrangement is similar to that of the second floor.



There will be a library and small day room in the male section and an outdoor screened porch in both sections.

The chapel, with a capacity of sixty persons, is located on this floor. It will have a sacristy with confessional and a conference room for the chaplain.

In the service area there will be two treatment rooms and two seclusion rooms which may be used for either male or female patients.

GROUND FLOOR (ALCOHOLICS AND OUTPATIENT DEPARTMENTS)

The ground floor is level with and connected to the ground floor of the present hospital. The alcoholic department,

located on this floor, will have two seclusion rooms. The treatment area contains two continuous flow tubs and other equipment.

The outpatient clinic, also located on this floor, is planned for outpatients' electric shock treatment and recovery, as well as other treatments. Within the clinic area are a lecture room, rooms for basal metabolism, electrocardiograph, electroencephalograph and consultation, examining and waiting rooms. There is provision for secret observation of patients during examination.

Also on this floor in the wing nearest to the general hospital will be the locker and dressing rooms for the male

employees, orderlies, nonresident nurses, and female employees. There will be an isolation unit consisting of two rooms with private isolation corridor, nurses' room, and sub-utility room. This unit is adjacent to and connected with the receiving room, which will be used for patients admitted under enforced admission, the ambulance entrance opening directly into this room. Adjoining is the admission toilet and bath. A private stairway leads directly to the "New Wing" administrative office that is located on the floor immediately above.

The arrival of the ambulance can be seen by the admissions clerk in the administrative office. The private stairway opening into the receiving room will be used in the disposition of infected or vermin infested clothing as it leads also to the disinfecting room and the incinerator on the floor below, and can be used by the isolation nurse in disposing of isolation waste.

BASEMENT FLOOR

The basement floor will house two insulin treatment and recovery departments, one for male and one for female patients. Each insulin treatment unit includes a nurses' workroom with visual control of large wards. There are toilet and bath facilities for the patients following the treatment. Cubicles are provided in each treatment room for difficult recoveries. Meals may be served following treatment from the service kitchen on this floor. Separate occupational therapy departments are provided for male and female patients, with arrangements for mixed use if desired.

The disinfecting room will contain a mattress and clothing disinfecting-sterilizer, with arrangement for clean and dirty sides. Also in this area will be a gas-fired incinerator. Disposal of waste from each of the upper floors will be made within a disposal closet opening from the corridor. Unlocking the closet door, the maid enters the closet where she can insert and shake a dust mop into a dust chute, or open a small door and deposit trash which falls into the enclosed trash room adjacent to the basement incinerator. The trash will then be raked over for valuables before being burned.

Storage space is provided on this floor and a distribution center for the mechanical equipment will be located in the south end of the building, where it will connect by a walk-through tunnel with the existing boiler house.

The gym-auditorium is planned as an all-purpose room. It will be used as a recreation room for patients and nurses. It will be equipped for basketball and other indoor games and will have folding bleachers seating 480. When set up for a meeting or entertainment, it will seat 850. The auditorium will have provision to store folding chairs on chair trucks under the stage apron. Ceiling height is 18 feet 6 inches clear, under the 36 inch beams. A glass enclosed balcony is provided for thirty patients, furnishing privacy for patients when desired.

The stage, 24 by 30 feet in size, will be equipped with appropriate scenery and settings.

It is planned to have the annual staff banquets, which have reached an attendance figure of 200, and the annual employees' Christmas party for 400 in this room. The floor kitchen is equipped to serve these large groups. The gym-auditorium will also be available for medical meetings and public gatherings in the interest of mental health. A modern projection room will provide facilities for motion picture shows and other exhibitions.

GENERAL ITEMS

The building will be of reinforced concrete construction with masonry curtain walls. The general finish of the building will include terrazzo floors and wall bases, acoustic tile in areas where necessary, and a practical placement of tile wainscots in service rooms and toilets.

Generally, all patients' bedrooms will have a small wardrobe with the floor raised 6 inches to facilitate cleaning. As part of this unit, there will be a small built-in table, which will take the place of a movable table within the room and will provide a writing desk or space on which the patients can put their personal belongings or keepsakes. It also is sized to take a food tray.

The entire building will be heated with circulated hot water through cast-iron radiators on brackets, permitting easy cleaning under the radiators. All radiators in the alcoholic department and on second, third and fourth floors will have protection grilles, and no pipes of any kind will be exposed in patient areas. A study of the plan will show numerous pipe shafts which are large enough to permit a plumber to make repairs or replacements.

Particular study has been given to eliminate suicide features. As a no-suicide protection, the toilet stalls have

been designed without cross rails. The ceilings over the toilets stalls have been lowered and the doors are supported on the resulting short partition. There will be no toilet stall doors in the disturbed sections. All toilet bowls will be wall hung, with concealed mechanism. All exposed screws will be prison head type.

The doors to all patients' rooms will swing into the room. While the objection has been made to this method that the patient barricades the door, this objection is overcome by the introduction of glass vision panels in all doors on the second, third and fourth floors. These vision panels are inset in steel sash and are removable from the corridor side in the event the patient barricades the door. It is believed that the danger of persons in the corridors being struck by outswinging doors is a hazard to be avoided.

PROTECTION FOR NURSES

The first floor, which is the open hospital floor, will have a standard nurses' call system. All other nurses' stations will be interconnected with a nurses' protection alarm system. This in turn will be cross-connected with treatment and bath areas on the floor. An intercommunicating automatic telephone will be available in all nurses' stations and other important locations.

Exterior windows will be steel with safety screens on all except in the seclusion rooms, where detention screens will be used.

The following figures may be of interest:

Square feet per bed, 745.

Cost per bed, \$12,400.

Cost per square foot, \$16.64.

Cost per cubic foot, \$1.32.

These figures are for construction contracts and do not include furnishings, movable equipment, and floor pantry equipment.

The functional arrangement of the plan results in a beautiful and interesting exterior design as will be seen from the accompanying drawing. Finished in brick, with stone trim and simple symbolic ornament, it is believed that when viewed from any direction, the new building located in the beautifully wooded section of the hospital grounds will be a credit to the Order of St. Francis and the community which it serves, and when completed will provide humanized and scientific treatment of the highest order for those in our community who are suffering from a mental disease.

room, director's office, and additional offices for the staff and training school. This permits expansion of admitting and accounting space, a library and staff room, and record librarian's office in the existing building. The hospital shop, an innovation organized by the ladies' auxiliary for the sale of gifts, will be adjacent to the main waiting room and elevator lobby. The director of dietetics will have her office on this floor, as is appropriate with her administrative position. Supervision of her department is facilitated by the proximity of her office to the dietary area and by an interdepartmental communicating system.

Additional medical and surgical beds will occupy the third, fourth and fifth

floors. There are seventeen private rooms on the third floor and twenty-five private rooms on each of the fourth and fifth floors, all of which can be converted to semiprivate rooms if it becomes necessary. A treatment room, solarium, flower room, nurses' conference room and station are part of each nursing unit. On all floors a serving kitchen and nourishment pantry are provided. The inclusion of the latter was considered desirable in order to separate the services of the dietary and nursing departments and thereby avoid confusion of traffic with tray setups at mealtime. Special nourishments and crushed or cubed ice can be provided between meals and in the evening without having to keep the

large kitchen open. Utility rooms are adjacent to the dietary area, and this service core is conveniently located near the elevators.

Many new features have been included in addition to those already mentioned. Toilet facilities have been placed between two wards, as with private and semiprivate rooms, to eliminate the necessity of nurses carrying bedpans into the corridors. This will save much of the nurses' time. Stretcher and wheel chair storage has been provided on each floor. Every effort has been made to save the nurses' time in performing utilitarian functions so that more nursing hours can be devoted to the patients' care.

An entirely new obstetrics department will occupy the sixth, seventh and eighth floors of the new addition and provide essential facilities for the hospital. The delivery department is located on the eighth floor, isolated from the rest of the hospital. It includes five delivery rooms, one of which is for isolation delivery, and related scrub-up and sterilizing rooms, workrooms and preparation room. Four semiprivate labor rooms with lavatories between two and an observation desk with viewing windows provide a new feature to aid proper supervision of maternity patients. Locker rooms for doctors, interns and nurses are provided to ensure the maximum precautions against cross-infection. On the same floor are four four-bed wards, two general nurseries, and one suspect nursery. A formula room for the preparation and sterilization of formulas is provided, as are waiting, utility and kitchen facilities similar to those on all patient floors.

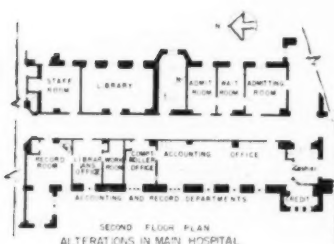
The sixth floor will have provisions for eighteen private patients, nurseries, an isolation suite, a special nurses'



Below: The basement of the new patient wing houses lockers and restrooms for employees, and housekeeping and storage space. The new service building basement is occupied by the pharmacy and by kosher and non-kosher food preparation rooms.

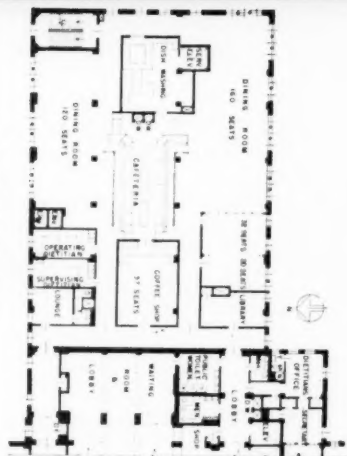


The second floor of the new addition is entirely allocated to administrative space. The second floor of the existing building is being altered to allow for expansion of the accounting offices, admitting space, library, staff room, and record library.



SECOND FLOOR PLAN
ALTERATIONS IN MAIN HOSPITAL

SECOND FLOOR PLAN
NEW SERVICE BUILDING



SECOND FLOOR PLAN
MAIN BUILDING

FIRST FLOOR PLAN
NEW SERVICE BUILDING



The pediatric department will be located on the first floor of the new patient building, while the first floor of the new service building will contain the dietary department, including bakery, dietitians' offices, and the dining room for the employees.

room, and a large solarium. The seventh floor includes sixteen semi-private rooms, four general nurseries, a waiting room, and solarium. A doctors' conference room and x-ray suite complete the facilities for the obstetrics department. New regulations for nurseries and other department standards have been included. A new feature is a mothers' teaching room in which instructions will be given to help them understand the problems of their new child. A need has been evident for some type of pre-home instruction as the mother is suddenly confronted with new responsibilities after having the

protection and sanitary standards of hospital care for several weeks.

Restrooms and locker rooms for the nurses, secretaries and employees and the linen storage rooms are located in the basement. A small laundry is provided for the nurses' personal use.

Surgical and Diagnostic

The third floor of the existing main hospital building has been reorganized and provides with the facilities in the new wing a highly integrated relationship among the surgical, diagnostic and clinical laboratory departments. The new surgical suite will occupy the new service wing, and a surgical nursing unit will be located in the new pavilion. Adjacent rooms in the existing building have been redesigned for endoscopic, cystoscopic and orthopedic work. Conversion of the operating



FIRST FLOOR PLAN
MAIN BUILDING

SUMMARY
FLOOR AREA
4,500 SQ. FT.
10,000 SQ. FT.

suite in the existing service wing to the new x-ray and diagnostic suite, and changing of the existing laboratories will complete the reorganization. These departments are modern in design and will be furnished with the most advanced equipment. This arrangement of departments resulted from frequent consultations with the staff.

The operating department, while an integral unit, is so planned that isolation is possible. In design it represents a new departure from traditional plans. To avoid a lengthy corridor and eliminate traffic, a second corridor was added. The operating rooms are air conditioned and artificially illuminated, and it was not necessary to place them on the exterior walls. Make-up and work rooms, instrument and anesthesia rooms are conveniently located to the operating area.

The design of the scrubup and sterilizing areas is more economical than is the traditional arrangement. Doctors are able to view the operating room without changing position, and better circulation in this area is possible. There are eight major operating rooms, two having observation space, and two minor operating rooms. An additional asset is a four-bed recovery ward, which makes it possible to have a highly trained staff caring for post-operative cases. A patients' waiting room and diet pantry are adjacent. A dictation room for recording operating procedures and results and surgeons' lounge, lockers and frozen section laboratory will be located in the service wing.

The x-ray department includes radiographic and fluoroscopic rooms, darkrooms, drying rooms, treatment rooms, and waiting room. Control and observation rooms provide adequate supervision. An office, file rooms, conference and viewing rooms are included.

New Service Wing

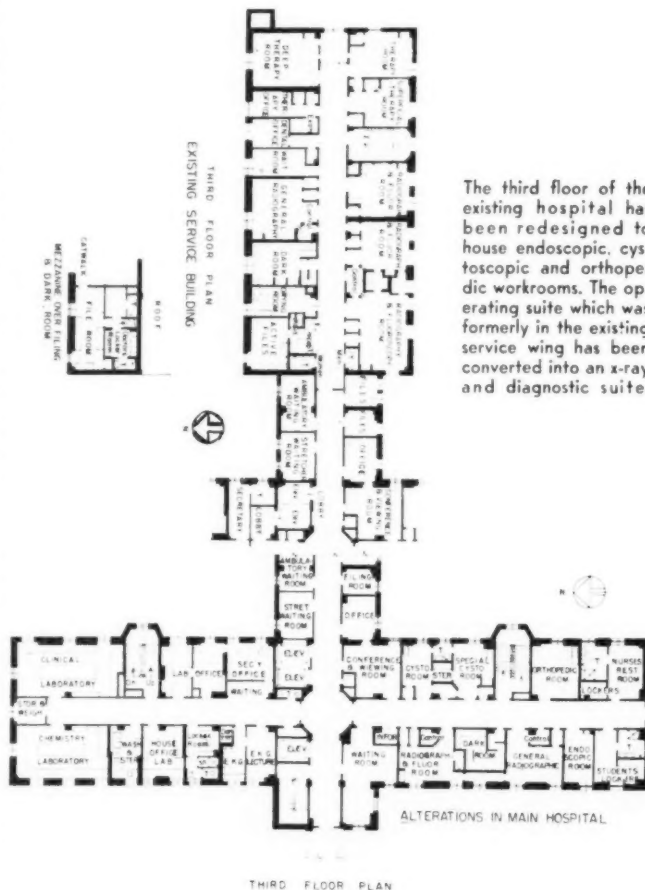
The dietary department was rapidly becoming obsolete when the new program was being crystallized. Careful study was made to determine whether the existing kitchen should be expanded or moved to the new service wing. Flow diagrams were prepared, and distances were studied. The new location proved to be the most economical and desirable from all considerations. A saving in distance traveled by workers amounted to well over a hundred feet. This, multiplied by the number of times traveled and the number of staff, results in a tremendous saving in employee hours. The physical restrictions

of the site did not permit placing dining rooms on the same level with the kitchen, but the resulting plan is efficient and compact and highly integrated in the horizontal and vertical circulation of the hospital unit.

The existing central tray service will be disbanded in view of the increased number of the patients' and staff meals. Bulk decentralized service will be installed with floor distributing and tray setup kitchens. The design of this department posed an unusual problem to the architect and to the kitchen consultant. Both kosher and non-kosher services are included, and considerable duplication of equipment and serving units was necessary. In addition to the desired flow of procedures to avoid cross-traffic, two separate relationships had to be established. Modern equip-

ment of stainless metal will be used throughout. The bakery, employees' dining room and dietitians' offices are included on this floor.

Dining rooms for nurses, interns and staff are located on the second floor and are accessible from the main lobby. The cafeteria is skillfully designed to serve the large dining rooms and the coffee shop. The latter is planned for the use of visitors and outpatients, and for the staff when the dining rooms are closed. Folding partitions permit subdivision of part of the dining room area into smaller, private dining rooms. Offices for the supervising and operating dietitians, a lounge, and the dietary library are located on this floor. These are closely related to the office of the director of dietetics in the administrative wing. Central dishwashing is lo-



The third floor of the existing hospital has been redesigned to house endoscopic, cystoscopic and orthopedic workrooms. The operating suite which was formerly in the existing service wing has been converted into an x-ray and diagnostic suite.

Central storage supplies, central sterilization and supply workrooms are located here with a private stairway connecting them to storage in the sub-basement. The pharmacy, blood bank, and bleeding room are related both to the main lobby and to the sterile storage. A passage connects the new service wing with the existing service building on this level.

A new interns' quarters will be located in the existing service building and will provide an extension of facilities on the second floor of the existing

A staff infirmary will replace the old pediatrics department on the fourth floor of this old wing. Interviewing rooms, a three-bed ward, and two private rooms and lavatory facilities are provided. This unit will make it possible to treat minor cases of staff injuries or illness without occupying patient beds.

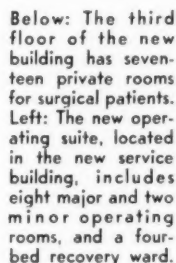
The laboratories of Beth Israel Hospital have expanded into inadequate quarters in the past years in an attempt to provide at least minimum facilities for the staff. Under the new program of expansion, these departments have finally been allocated sufficient area and well designed space and furnishings to carry on their extensive and rapidly increasing program of research.

tioned in connection with the operating and diagnostic suites, will include large clinical and chemistry laboratories, director's laboratory and office, house officers' laboratory, washing, sterilizing, electrocardiograph and lecture rooms. Additional laboratories for pathological and bacteriological work are located on the first floor of the existing service building in the area previously devoted to the dietary department. This has been completely remodeled and designed for spacious laboratories, department offices, technicians' laboratories, locker and rest-room facilities, storage refrigerators, and a photography room.

The Yamins Research Laboratory, the gift of Mr. and Mrs. Nathan Yamins, will provide the most modern facilities for research in connection with a hospital that have yet been built. Twenty-eight laboratories, examination rooms, staff offices, chemical supply rooms, refrigerators, darkrooms, scale room, and restrooms are some of the features of the building. On the first floor are students' classrooms, large lecture rooms, and the memorial hall and library. One laboratory will be equipped with a large, specially designed concrete cabinet and an acid resisting sink to hold radioactive specimens and to protect laboratory workers from the rays. The medical laboratory department with its examination rooms, laboratories and offices occupies the second floor, the surgical laboratory department, the third floor.

The building is modern in design with large glass areas and is faced with buff brick to harmonize with the other buildings. An underground passage connects the new unit with the outpatient building.

These new laboratory facilities will make it possible to carry on more intensive study of medical problems. Research will be concentrated on the fields of blood diseases, circulation, cancer and thyroid.



RADIANT HEATING is practical for hospitals

JOHN K. M. PRYKE

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BEFORE dealing specifically with the question of radiant heating application to hospitals, it may be as well to establish what exactly is meant by radiant heating and what principles a well designed system should follow. I believe it is necessary to do this because of the various forms of radiant heating systems which are being developed, and also because of claims which

are often made on behalf of installations that they are radiant heating, whereas, in fact, they are merely modified convector systems.

As is well known, the human body loses heat mainly by two means, direct radiation and convection. The conventional type of heating system aims, basically, to warm the air in the space served and thus give comfortable con-

ditions to the occupants by offsetting their convection heat loss. The radiation loss from the body can be offset by providing a source of radiant energy whose heat rays impinge on the body, and this is the basic aim of a properly designed radiant heating system.

In order that the radiant energy may be distributed effectively throughout the space served, the radiating area should obviously be large. In practice, it has been found that quite low temperature radiating sources are highly effective in giving comfort, and hence a radiant heating system should be designed to provide a large amount of low temperature surface.

Theoretically, the use of any of the six plane surfaces in a room as the radiating surface will ensure comfort conditions for the occupants. However, from practical considerations, the possibility of the use of the walls is largely eliminated owing to obstruction from furniture or other fixed objects in the room; in addition, the relative movement of the occupants to the walls varies the heating effect. Wall heating is, therefore, undesirable except directly below or adjacent to window areas, where it offsets the high heat loss through the glass. As regards the floors, it is found in practice that there are severe limitations to the surface temperatures which can be carried because of the effect on the occupants' feet. Additionally, there is a considerable factor of uncertainty introduced when floor coverings such as wood, tile or linoleum are used. While the reaction of these in many cases may be negative, it has been my experience that their behavior is always likely to be an uncertain factor, and the possibility of trouble being experienced from instability is always present.

The ceiling presents the most unobstructed and stable surface in a room, and it has been found in general that it forms the most suitable radiating surface. Some of the reasons for this will be dealt with later, and it must be borne in mind that the previous



remarks cover conditions experienced in large multistory buildings and not special applications such as are encountered, for instance, in single-story industrial buildings.

Now as to how to heat the radiating surface. The most satisfactory method of doing this which has hitherto been developed is by embedding pipes just below the surface through which warm water is circulated. Embedded air ducts carrying heated air and also embedded electrical heating elements have also been used to a small extent, but the warm water pipe systems are the most commonly used. Thus, a well designed radiant heating system produces a large surface of low temperature radiation, preferably using the ceiling as the surface with low temperature hot water as the heating medium.

Now let us consider some of the main features of such radiant heating systems. First, there is a complete absence of any visible apparatus or pipe work because the heating coils are embedded and, in addition, the supply mains and risers can also be embedded. This immediately indicates that the system is essentially a clean one. Owing to its operating principles, dust carrying convection currents are not created, as happens with a conventional system. It has been found in practice that the necessity for redecoration and cleaning is materially reduced. This was proved particularly in England during World War II where practically no interior decorating work was allowed between 1939 and 1945. At the end of this period, it was noticeable that buildings having radiant heating installations were much cleaner internally than were those with conventional heating systems.

The second point to consider is the comfort effect. The relative humidity of the air in a room heated by a radiant system is considerably higher than that in a room heated by conventional means. Additionally, when

the ceiling is used as the heating medium and the heating coils are correctly arranged, it is found that the usual "cold radiation" from the windows on a cold day is entirely offset.

There is no "steaming" on the windows, even with single pane glass under the severest outdoor conditions, and it is quite possible to stand within 9 inches of a large glass window without any feeling of discomfort. This means that, with radiant heating, large glass areas can be used without any risk of discomfort to room occupants. Note in this connection the fenestration of the Buogerspital at Basle shown in the accompanying photograph. This building is designed to operate at an outside design temperature of -4°F .

EXTERNAL PROTECTION ASSURED

Third, if the pipe coils are properly embedded in plaster or in concrete, external protection is adequately assured and the analogy of metal wire lathing in hung ceilings and reinforcing rods in concrete may be drawn. As regards internal corrosion, the heating medium circulated, *i.e.* low temperature hot water, has a negligible effect on piping of ordinary materials because with a properly designed closed system there is no make-up, or fresh water, entering and, in addition, the temperature of the circulating water is too low to free its oxygen or to "throw" its hardness.

It has been found that embedded steel radiant heating coils after nearly forty years' service are in as good condition as when they were installed. If the proper practice of welding all embedded pipe work joints is followed, no trouble is experienced with leaks, and the actual maintenance on a well designed totally embedded system is negligible. This has been well proved over many years, especially in England and Europe where there are more than 2000 of these systems in large multistory buildings, the first

major installation dating from 1909. Many American engineers and designers prefer wrought-iron pipe; specially tempered copper pipe also has its advocates.

In the design of a hospital, there are certain fundamentals to be considered, two of the most important of these being cleanliness and quietness. These may be considered as over-all rulings governing individual design of components. Then as regards detailed design, the provision of good fenestration is, of course, of great importance.

Does the conventional type of radiator system, whether steam or hot water, adequately meet the building conditions thus imposed? As regards cleanliness, the answer with any type of radiator system is obviously no. It is customary to use specially designed radiators for hospitals which have plain surfaces, but even so, these form effective lodging places for dirt and dust, and, in addition, the piping connections form angles and corners to trap dust. Additionally, owing to the convection currents set up by radiator or convector systems, wall smudging is an attendant feature of their use, and this involves cleaning and redecoration at frequent intervals.

As regards noise, hot water radiator systems meet the requirements, but steam systems frequently do not because of water or steam hammer and vibration from faulty traps.

On the score of fenestration, the answer is "partially." The heat loss through the windows is usually looked after by placing radiators directly under them. This is not possible where full length glass windows reaching to the floor are used, as is frequently done in solariums or in "open air" rooms, and in these instances, it is difficult to counteract the chilling effect of the large glass areas with radiators.

Let us consider whether radiant heating can meet the requirements more
(Continued on Page 120.)

Opposite page:
Laying the panel
coils in a new
building. Right:
Eighty miles of
panel coils heat
and cool the
Buogerspital,
Basle, Switzer-
land, where low-
est outside tem-
perature is -4°F .



The hospital is incomplete without a

DENTAL SERVICE UNIT

JAMES S. MILLER, D.D.S.

Assistant Chief
Dental Division
Public Health Service

"The purpose of Public Law 725, as stated in the Act, is to assist the States in planning for and obtaining facilities for furnishing adequate hospital, clinic and similar services to all their people. To be adequate, such services must include dental care. The Public Health Service is delighted to have this opportunity to assist in the promotion of the ideals and aims of the American Dental Association and the American Hospital Association in developing better patient care."—LEONARD A. SCHEELE, Surgeon General, P.H.S.

DENTAL service in hospitals, a long neglected field, is rapidly assuming its proper rôle in national efforts to achieve the goal of better health. Public recognition of past and potential contributions of dentistry to public health and the national economy is exemplified in action of the 80th

Congress in enacting legislation establishing a National Institute of Dental Research within the Public Health Service. Hospitals of all types and sizes and public health programs have an opportunity to contribute to the success of this new institute as well as to benefit by its accomplishments.

Without dental services in hospitals, the patient cannot receive a complete diagnostic analysis of his condition. Total treatment cannot be accomplished, and potential causes of disability remain to permit future discomfort, illness, chronic diseases, and immeasurable economic loss. Oral surgery for repair of injuries and for eradication of infections of dental origin requires the services of a competent dental staff.

Despite these facts, too large a proportion of even the larger hospitals are not making available to their patients

J. R. McGIBONY, M.D.

Assistant Chief
Division of Hospital Facilities
Public Health Service

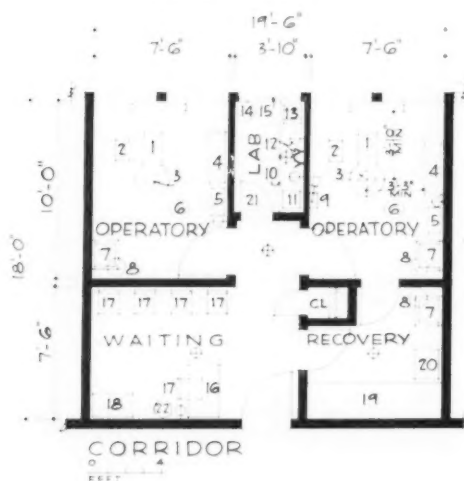
a service that is necessary to provide adequate care.

In the nonfederal hospitals, dental departments exist as follows:

All Sizes	Under 50 Beds	50-99 Beds	100- 249 Beds	Over 250 Beds
17.1%	7.6%	10%	24.4%	61.7%

In addition to providing dental care as a part of total patient care, hospitals also have a definite responsibility in the educational field relating to dentistry. Within a few years it is anticipated that dental graduates, who now complete practically the same curriculum as medical students, will be required to serve a hospital internship before being licensed to practice. Hospital planners must have vision enough to foresee needs for physical facilities, clinics, staff and administrative procedures to assume this educational load.

ILLUSTRATION I



DENTAL SUITES WITH
TWO OPERATING ROOMS

1. Dental chair
2. Dental unit
3. Dental operating light
4. Dental instrument cabinet
5. Instrument sterilizer 4 by 6 by 16 inch
6. Adjustable stool
7. Lavatory with gooseneck spout and knee control
8. Towel receptacle
9. Dental x-ray
10. Laboratory counter, 36 in. high with cabinets below
11. Sink in counter
12. Gas, air and electric outlets
13. Developing tank
14. Compressor
15. Lightproof shade
16. Desk, 20 by 36 inch
17. Straight chair
18. Filing cabinet
19. Built-in couch
20. Bedside table, 16 by 20 inch
21. Lightproof door with louver
22. Waste paper receptacle
23. Surgical instrument cabinet
24. Instrument table

They must be among the leaders and not simply the followers of progress.

All hospitals may not need extensive facilities and equipment for complete dental services. If competent consultation is available in every hospital, much of the actual treatment, including surgical procedures, may be more economically furnished elsewhere. This can be done through an efficient integration and coordination of hospital activities, through health clinics, by group or private practitioners. Such methods must be determined and applied in the light of local needs and policies by combined efforts of leaders in the medical, dental and hospital fields.

Standards for dental services in hospitals have been established through a joint committee and officially approved by the American Hospital Association and the American Dental Association.

An outline of these standards is as follows:

1. *Hospital Department.* The title of the department responsible for the hospital dental service should be "Department of Dentistry" or some similar title containing the word "dentistry" or "dental."

2. *Hospital Rules.* The department of dentistry should be organized under the direction of a dentist, preferably one engaged in the general practice of dentistry, to function like other departments.

3. *Dental Staff.* All dentists privileged to practice in the hospital should be organized as a definite group or staff. Dentists who are being considered for appointment to dental staffs should have qualifications, such as previous hospital experience, technical ability, and scientific training, that would be expected of any other staff member.

4. *Dental House Staff.* Whenever possible, hospitals operating a department of dentistry should provide for dental interns and residents appointed according to the usual regulations of the hospital. Dental internships and residencies should conform to "Requirements for Approval of Dental Internships and Residencies" established by the Council on Dental Education of the American Dental Association.

5. *Functions.* The department of dentistry has three main functions:

Administrative: To act in an advisory capacity through customary channels on problems related to the dental services.

Clinical: To render professional service to the patients in accordance with the precepts of modern scientific dentistry, to maintain its own efficiency, and periodically to audit the professional work.

Educational: To help train staff members, dental residents and interns, dental hygienists, dental assistants, and nurses in order that their

knowledge and fields of usefulness will be increased.

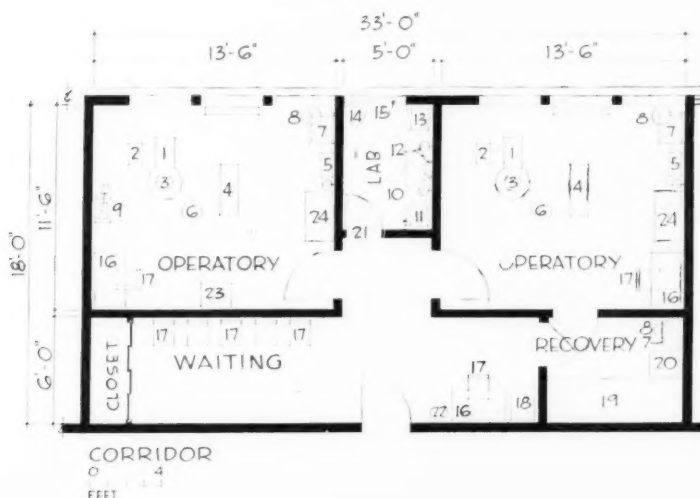
6. *Organization.* The dental department should be under the direction of a dentist designated by title as are other service chiefs. The chief of the dental department should be selected for his professional and executive ability on the same basis as other department chiefs. The chief of the department of dentistry should have the same privileges regarding appointment to the medical board or executive committee of the hospital as have other department chiefs. The dental department personnel should attend and participate in general staff conferences. Special effort should be directed toward adequate training of the interns and residents. Clinical investigations should be encouraged in the dental field.

7. *Dental Hygienists.* Whenever possible, dental hygienists should be appointed to the department of dentistry.

8. *Physical Equipment.* The space allotted to, and the equipment, instruments and supplies of, the department of dentistry should be adequate for such services as may be carried out by the dental department in accordance with generally accepted standards of practice.

9. *Rules.* The department of dentistry should function with a systematic plan of management based upon

ILLUSTRATION 2



rules set up by the hospital for other services within the hospital.

10. *Records.* Dental records should be a part of the hospital record system. A uniform method should be established for recording data.

11. *Library.* An adequate selection of dental books and periodicals should be available in the hospital library.

12. *Formulary.* A standardized departmental formulary, based upon "Accepted Dental Remedies" of the American Dental Association, should be adopted and included in the general formulary of the hospital.

MINIMUM DENTAL SERVICE FOR HOSPITAL PATIENTS

The hospitals should rapidly evolve a department of dentistry with adequate facilities to assume the responsibilities for a more nearly complete dental service for patients on the wards and in the outpatient clinic. In order to extend dental care in that direction as rapidly as economic and manpower resources will permit, the following general plan is suggested:

The extent of the dental service provided by the department of dentistry will vary in accordance with (a) the size of the hospital, (b) the type of hospital, (c) the kind of service rendered by the hospital. For example, in hospitals for tuberculosis, mental diseases, and crippled children more nearly complete dental service is necessary.

It is recognized that an ideal program would include a complete oral examination including a complete dental roentgenographic interpretation as a routine for hospitalized patients. Outpatients should be afforded the same service when facilities permit. However, with the present limitations of personnel and general development of dental departments, it would seem desirable to postpone such a requirement as a minimum standard. Dental consultation should be made available by the department of dentistry to the several other departments in the hospital.

A department of dentistry should be responsible for the services as follows:

1. *Dentistry for Children.* In certain types of hospitals where children are hospitalized for an extended period of time, i.e. those serving crippled children and children with chronic diseases, the practice of pedodontics and orthodontics is a necessary service.

Orthodontic service should be available to children's hospitals for consul-

tation and treatment. Cleft palate cases especially need this service.

2. *Restorative Dentistry.* In certain types of hospitals, especially those serving patients suffering from chronic diseases, such as tuberculosis and mental diseases, restorative dentistry is a necessary service.

Carious lesions of the teeth should be treated in the early stages by properly preparing the teeth and by using an appropriate type of filling material to restore the teeth to usefulness and to prevent pain and infection.

Complete and partial artificial denture service should be available for patients with extended hospitalization.

This department should be responsible for the construction of splints for fractured jaw cases, and radium splints for malignant cases.

3. *Dental Roentgenology.* The members of this section, if they do not take the dental roentgenograms, will at least be the consultants to the roentgenographic department for cooperative diagnosis of all dental roentgenograms.

4. *Oral Surgery.* The work of the section of oral surgery in relation to the hospital outpatients and inpatients lies in diagnosis and surgical treatment. Treatment should consist of surgical eradication of acute and chronic oral infections.

The department of dentistry should assist existing schools of nursing to prepare all nurses for participation in the oral health care program.

PHYSICAL FACILITIES

1. *Location.* Facilities for dental services are usually best located in an area easily accessible to both inpatients and outpatients. To serve both groups it may be somewhat difficult to eliminate cross-traffic completely. Such traffic, however, should be kept to a minimum.

2. *Operator.* Dentists are practically in full accord with the belief that there is never any reason for installing a single chair unit, even though only part-time work is contemplated. Two chairs permit a single dentist to perform several times the amount of work possible with only one chair. They conserve the time of these specialists which would otherwise be consumed in waiting between patients, cleaning up, or performing other duties more properly done by an attendant.

It is realized that because of limitations of existing buildings, or of funds for construction or remodeling, it is

not always possible to allocate the ideal space. Suggestions given here are for adaptation to local needs in the light of practicability. If only one operator is possible in the beginning, it may be designed by adaptation from the accompanying sketches. In this event, future expansion should be anticipated.

A virtually irreducible minimum for each operator is 10 feet by 7 feet 6 inches, as shown in illustration No. 1. In addition, space for laboratory, waiting, recovery and desks would be needed. These small sizes also may be satisfactory for the private practitioner's office, where extensive operative work is usually not undertaken, and where rental on a square foot basis is high. This minimum plan was published in "Elements of the General Hospital" in the July 1946 issue of *Architectural Record*.

Increasing functions of the dentist indicate a need for enlarged working areas. The area must be sufficient in width to accommodate the equipment with the operator in position beside the chair. It must be long enough to allow the patient to be placed in the fully recumbent position, with the operator at the head of the chair, and to permit free passage of the dental assistant around both chair and operator.

Such a plan is suggested in illustration No. 2. This is considered the ideal; yet where space and funds are at a premium, size might be somewhat reduced. This is particularly true of the passage between the dental cabinet and the instrument table (equipment legend items No. 4 and No. 24), which might be reduced by 18 inches.

3. *Laboratory.* The size of the laboratory will depend to some extent upon the amount of prosthetic work to be undertaken, but usually should be not less than 4 feet by 5 feet. As the laboratory is also used for development of films, it requires a developing tank and lightproof shade. A counter with built-in sink and cabinets below is necessary. Gas, air and electric outlets are required. The compressor may be placed here.

4. *Recovery Room.* As in surgical areas, the trend is toward provision of facilities for recovery of the patient under the operator's or anesthetist's supervision. A couch and bedside stand are necessary. A lavatory is desirable.

5. *Waiting Room.* In addition to the hospital's general waiting room, it
(Continued on Page 130.)

PURPOSEFUL USE OF THE STAFF OFFICE

Staff office space within the hospital permits the doctor to serve his patients better without financial risk and enhances the usefulness of the hospital to the community

WE DEFINE the "Staff Office" at Passavant Memorial Hospital, a 280 bed teaching institution in Chicago, as a group of rooms and a corridor off the main foyer, set aside for the purpose of care for outpatients. It is not a clinic in the sense that there is no definite assignment of space, time or medical personnel, nor does the hospital receive any direct revenue from each staff office patient *per se*. It does not compete, for instance, with the part-pay or free clinic in the medical school building, which is on another part of Northwestern University professional school campus. The patients all have a private or industrial status or, if they are nonpaying, this situation is under the control of the attending physician rather than of the hospital or social service.

The staff offices were designed and built as such. The space they occupy was not altered or prepared later for this purpose. The corridor is entered from the foyer, and it and the recesses seen are furnished with adequate waiting room facilities (fig. 1). Also off another portion of the foyer is the gift shop where refreshments and light meals are served. The pharmacy is at the opposite end of the corridor and it

serves the needs of the hospital and the outpatients alike.

A page board is placed on the wall for doctors' calls and two telephones are available. The staff "in-and-out" board, turned on when the doctors enter the side entrance of the hospital, is reproduced above the nurses' desk in the staff office as well as in the telephone room, so that the attendants may know at a glance which members of the staff are in and thus answer promptly inquiries of patients. All calls coming to the hospital that require medical information or a reference for specialized services are referred to the staff office desk and handled there.

Ten examination and treatment rooms are available. Five of these, approximately 8 by 10 feet in size, are equipped with sink, cupboard for dressings, medical examining table, chairs, and a smaller rolling table used for writing, doing hand dressings, and the like (fig. 2).

The other five rooms consist of a large examining room with a blackboard, which is suitable for student or conference groups; an eye room, complete with diagnostic instruments, such as ophthalmoscope, tonometer, emergency instruments, projection charts, slitlamp with binocular microscope, trial lenses, perimeter, tangent screen—in other words, all equipment necessary for the practice of outpatient

ophthalmology; an ear, nose and throat room, equipped for the practice of this specialty; a clinical laboratory, where routine tests are made and supplies and equipment for the other rooms are prepared, and a room designed for obstetric and gynecological examinations and treatment of minor conditions in this field.

The patient on arrival registers with the nurse in charge and is told whether the doctor is in, how many people are waiting, and so on. It may be that she is not to see the doctor at all but is bringing a requisition slip for certain laboratory or x-ray tests. If the requisition calls for a blood count, urine analysis, warm stage stool examination, gastric contents, or glucose tolerance, such tests will be done there. The various chemical studies will be done in the main hospital laboratory, but the blood will be drawn in the staff office. Here, also, appointments will be made

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FIGURE 1



Figure 1: The recesses seen from the corridor are furnished with adequate waiting room facilities. Figure 2: Examining rooms, 8 by 10 feet in size, are equipped with sink, cupboard, examining table, chairs and a small rolling table for dressings.

FIGURE 2



for metabolism tests, x-ray examinations, electrocardiogram or other special investigation work on an outpatient. The patient is charged for such tests and may either pay at the time or receive a bill from the business office of the hospital.

The charge slips made out during the day are the responsibility of the attending nurse, and they are turned in to the main office at the end of each working day. Mailing reports to the doctors on laboratory examinations is also the responsibility of the staff office attendants. No additional service charges for the use of these facilities are made to the patient or to the doctor. Also, no service charge is made to patient or doctor for the simple use of any of the examining rooms for general physical or special examinations using the available equipment described before.

Charges are made to the patient, however, for the materials used in dressing wounds. Facilities are not available in this space for larger outpatient orthopedic procedures so these are carried out in one of the several units of the emergency room, one floor below, served by the automatic elevator, or in the plaster room on the operating floor.

HOW DOES IT SERVE?

This, then, is the outline of the physical and personnel facilities of our staff office. How can these facilities used here, or in your hospital, be put to the best use for the individual patient, for the community of which the hospital is a part, for the hospital itself, and for its house staff, for whose teaching the attending staff is responsible?

For the Patient: He is received in an established department in a community hospital. He is confident through what he has heard or through previous visits there that he will receive prompt, courteous and efficient service. All the usual needs of the average outpatient can be and are met in this one department, including admission to the hospital if necessary. If this is his first visit he will meet others whose problems may be similar, and a friendly spirit frequently develops among patients in certain groups. This opportunity to compare time, men, methods and results gives them "a place on the team," so to speak, and helps to develop that mass psychology which has been shown to be an important factor in individual rehabilitation.

This psychology is particularly important with the compensation patient. We all know that any tendency toward malingering or development of traumatic neuroses can be thwarted more effectively by a fellow patient with a similar affliction and a normal desire to recover in a reasonable time than it can by a doctor who, in the processes of a suspicious mind, might be considered to be working primarily for other interests. This same spirit is, of course, carried on in the department of physical medicine where many outpatients are treated also.

The patient is given, in addition, the benefits of group practice. Informal consultations among doctors using the staff offices are frequent, as are instances in which there is an actual transfer of responsibility. On-the-spot reviews of wet x-ray films with the roentgenologist, who is in full-time attendance, make possible diagnosis and/or changes in the course of treatment without the delay necessitated by waiting for drying of films, by a visit to another building, or by mailing a formal report. Clinical laboratory findings may likewise be discussed promptly with those expert in this field.

Furthermore, the patient becomes known by many other persons than his attending doctor. The fellows in the department, the residents, interns, clinical clerks, nurses and technicians are all concerned with his care and all have at one time or another manifested their interest in his case. This gives him security in the knowledge that many of his needs can be met should occasion arise in the absence of his own doctor.

For the Community and the Hospital Which Is a Part of It: The phenomenal development of various plans for hospital care has resulted in a greater dependency of the public upon the individual hospital and has therefore increased the responsibility of the hospital to the community. An adequate staff office affords an additional opportunity for service that cannot be rendered in the average doctor's office, and its purposeful use will do much to guide the trend toward centralization of medical practice into channels which will be beneficial for all.

For the hospital which must obtain and maintain the good will and support of the public, this can be done without competing with the doctor, and in such a way as to increase the institution's actual income and cer-

tainly add to the possibility of its potential income. We are all familiar with the difficulties being encountered in various hospital drives throughout the country today. Heavy taxation, from which there is no appreciable relief in sight, is reducing the number of donors of substantial amounts. There will be fewer and fewer hospital pavilions and wards named in the memory of one able to endow them in perpetuity. This being true, the hospital will become more and more dependent upon the small gifts of many rather than the large gifts of a few, and this source must be available. The staff office list, like the admissions list, can be used as a source of material.

For the House Staff: One of the principal drawbacks of the average internship and residency today is the lack of adequate outpatient teaching. The young man in these important training years is frequently subjected to a lopsided experience. Too often, he sees a patient for the first time in a hospital bed, admitted there by his superior, and many times bringing with him a list of things to be done for either diagnostic or therapeutic purposes.

SECOND-HAND KNOWLEDGE

The intern enters the drama in the middle of the first act instead of participating in its beginning, and gets in touch with events gone before in a second-hand way, influenced by the interpretation of another. He has not made his own decision; he has had some of the responsibility lifted from him and some of the work done for him. After the patient's release he will not see him again and only if he has proper interest and adequate memory will he obtain from the attending doctor a report of subsequent events—again influenced by another's interpretation.

How is he to learn the time element in healing, in the recovery of function, if he does not himself participate until the conclusion? How is he to learn what to expect of a patient two, six or ten weeks after a given procedure? How, if he does not see the end result, is he to learn to give a correct prognosis or to estimate a disability with justice to all concerned?

The purposeful use of staff office space as an outpatient department will do much to overcome this common defect in the training of young medical men and women and will make the

hospital a more desirable internship and a teaching as well as a treatment center. The additional contacts provided in such a plan, with attending men and patients alike, will permit a greater influence to be brought on the trainee and hasten his medical maturity.

For the Attending Staff: It may be argued that the adoption of such a type of practice in the hospital would place the institution and the individual doctor in a competitive position. To foster such a thought one would first have to deny the trend toward group practice and then deny the hospital its rightful place as a medical center of the community. The hospital and its staff office should take the place of the back room of the corner drug store where our fathers in another day met and discussed their common problems.

MAY COMPETE WITH SPECIALISTS

It is true that the hospital, through its staff office, does compete for outpatient service with the doctor in the private practice of roentgenology and clinical laboratory medicine. The national societies in these specialties have been interested in this problem for years, and there is no unanimity of opinion as to the proper relationship between the hospital and, let us say for example, the head of its x-ray department.

Some radiologists are on a straight salary. Others are paid on a percentage basis of the business done by the department. Others receive an income from both the hospital and their own private practice in an outside office. Inasmuch as the x-ray and laboratory facilities are there for the use of inpatients, it is only natural that attempts should be made to develop their use for outpatients. It is a well known fact that the x-ray department of any hospital operates at a substantial profit and most hospitals take advantage of this to carry departments, such as pathology, which are not and perhaps never will be self-sustaining from the financial standpoint.

The hospital is, or should be, equipped in material and personnel to render x-ray, clinical laboratory, and physical therapy service superior to most and equal to any such services that can be obtained in the office of a practicing physician. Whether or not the doctor will avail himself of these services will depend upon his pattern of practice.

The physician whose pattern of prac-

tice calls for all these services in his private office will, of course, look upon the development of hospital outpatient facilities as unfair competition. The physician whose pattern of practice does not involve the retailing of the services of others will welcome these hospital facilities because they relieve him of the responsibility and financial risk of such multiple enterprises and permit him to devote his efforts to the management of the sick or injured. He will be more the physician, for which he was trained, than the business man, in which field so few of us are competent.

The use of these hospital facilities would also go a long way toward minimizing the practice of rebates and division of fees, which at times and in places is practiced to the detriment of the profession as a whole. These are provocative statements, but the thoughts contained are those of the trends and

problems which we must meet. The purposeful use of the staff office is a recognition of the trend toward group practice, and no physician can fail to benefit by the closer contact which this makes possible with his superiors, his equals, and those he is obligated to train. He will be stimulated by the frequent association, the exchange of ideas, the interpretations, and the example of others.

This paper does not advocate, necessarily, the development and maintenance of private offices in the hospital for all its staff, but it is hoped that it brings out some of the good that can be accomplished by the purposeful use of a staff office, as opposed to the convenient use, to all concerned. These thoughts are based on our hospital's experience with such a system since 1929 and a patient census totaling 23,365 staff office visits in the last fiscal year.

Memo to Employees Re Kindness

THE following memorandum distributed to the personnel of New England Center Hospital, Boston, contains a message for both employees and administrators. The small courtesies

and acts of kindness, such as the one reported here, make all the difference in the world to the patients, and to the reputation of the hospital in the community which it serves.—Ed.

MEMORANDUM

A MAID, hurrying through the basement of the hospital to go down town on an important personal errand during her lunch hour, saw an elderly patient looking bewildered and obviously lost. Immediately going to the patient, the maid asked if she could help, and then taking the patient gently by the arm guided her to the elevator. The maid did not merely put the patient on the elevator, but she went up in the elevator with the patient and took her back to her room. After a few reassuring words the maid went to the head nurse and reported the incident. By this time it was too late for the maid to complete her own errand, so she went to the locker room, took off her hat and coat, and then reported back to duty.

That same day this patient was visited by an internationally famous physician. Men trained in internal medicine, radiology and research studied the problem of this patient and all made their contribution in helping to find the cause and cure of that patient's illness—but none contributed more than the maid with her simple act of kindness.

A hundred such acts of kindness are done each day in the thousands of hospitals scattered across our country. We think that the kindness of the maid is just as important to the patient as any other contribution.

R. T. VIGUERS
Administrator

NURSING service in the Public Health Service hospitals is provided by graduate professional nurses and attendants who are trained on the job. The nursing department is also responsible for the serving of food to patients, and for housekeeping in the hospital and in the quarters for nurses and attendants.

The preliminary surveys of the nursing service in several Public Health Service hospitals indicated that the basic need was the development of a program for more efficient and economical utilization of the nursing service personnel. The question of using practical nurses was also posed.

A group was called together to suggest a course of remedial action. In addition to Division of Hospitals headquarters staff members, the group included, among others, an expert in job analysis, an outstanding director of a school of nursing, an administrator of a civilian hospital, and the executive secretary of the Association of Practical Nurse Education. This group recommended that a comprehensive study be made of the utilization of all nursing service personnel in one hospital, to determine in terms of improved patient care the need for a revision of nursing service methods and in-service training for all nursing service personnel.

An analysis of the time spent in the performance of the various patient care activities in one service hospital revealed that nurses were spending approximately 46 to 52 per cent of their time performing nonprofessional activities, which in many instances were also being performed by attendants. Hence, the time available for professional nursing care of patients was reduced. Other findings of the study indicated a need for improved ward administration and supervision, for revision of nursing service policies and procedures, and for a rearrangement of activity schedules and hours of duty.

Some of the questions which naturally follow a review of such findings are:

1. How can more economical use be made of each individual's time?
2. Which of the activities now performed by professional nurses can safely be delegated to nonprofessional personnel?

A procedure for reorganization for

BETTER USE OF NURSING PERSONNEL

ELSIE T. BERDAN

Associate Chief, Nursing Section
Division of Hospitals, Public Health Service

3. What kind of training is required by the nonprofessional personnel and how much of it does it need?

4. What type of in-service staff education program will serve best the needs of the nursing service personnel?

5. What changes in the administration of the nursing service are necessary before additional nonprofessional personnel and perhaps other types of workers are added to the staff?

6. What is a safe numerical ratio of professional to nonprofessional nursing service personnel?

7. How will this affect the total cost of the nursing service?

The desire to find the answers to these questions provided the incentive for a more intensive study of nursing service personnel utilization, and for extensive reorganization of the nursing service in the hospital chosen for the study.

The procedure to be described has resulted in improved patient care, which is the primary objective of the reorganization of any nursing service. It has also effected more efficient and economical use of all nursing service personnel. A better concept of the rôle of the professional nurse in relation to other personnel has developed. The enthusiastic interest and the improved morale that grew with allowing time and providing opportunity to carry out an all-inclusive patient care program created a new and stabilizing influence in the nursing service staff.

The steps followed, although designed for purposes of the study, actually constituted an in-service staff education program, based upon the principles of active participation by all members of a group and recognition that the success of the program depends upon the quality and practical value of the instruction. This procedure, as it developed, met the needs of a group to achieve unity of purpose, to improve efficiency, and to stimulate personal and professional growth.

The initial step in the procedure was the appointment of an executive committee at the headquarters office to coordinate all the activities involved and to facilitate the necessary reorganization of the nursing service. Inasmuch as such reorganization could not be possible without the full cooperation of all personnel at the hospital, the medical officer in charge and the director of nursing service in the hospital selected were invited to meet with the executive committee to participate in the formulation of a plan of action. All steps in the procedure were charted carefully in order to achieve the objectives without too much interference with the hospital routine.

In the absence of a qualified executive housekeeper, one of the assistant directors of nursing was appointed to act in that capacity. She was assigned the task of planning a housekeeping department.

A working committee was organized

"We Believe It May Be Helpful to Other Hospitals"—The Medical Director

THE Division of Hospitals of the Public Health Service operates twenty-four hospitals with a daily average load of 5700 patients. While these hospitals are administered through the headquarters office in Washington, each hospital retains a certain degree of autonomy of operation. Medical care is provided by resident staffs. Professional nurses are assigned to the hospitals by the nursing section of the headquarters office. All other nursing service personnel is selected and appointed by the individual hospitals. Administrators of federal govern-

mental hospitals, like others, seek the answers to two important questions: How can we give our patients the best possible care and keep the cost of nursing service personnel at a minimum? How can the nursing service staff be stabilized? The procedure described in the accompanying article is presented as one approach to the problem of effective and economical utilization of nursing service personnel.

Preliminary surveys and plans made by Eugenia K. Spalding, now director, Division of Nursing Education, University of Indiana, were followed by

the nurse utilization study directed by Jane E. Taylor Torrence, formerly Public Health Service Consultant for Nursing Education. The study was continued under the direction of Elsie T. Berdan, assisted by Ruth L. Johnson, Public Health Service Consultant for Nursing Education. Completion of the study would not have been possible without the cooperation of Dr. Kenneth R. Nelson, medical director, and the staff of the hospital in which it was conducted.—OTIS L. ANDERSON, *medical director, chief, Division of Hospitals, Public Health Service.*

at the hospital to develop a plan for the reorganization of the nursing service, with reallocation of all activities to the nursing, dietary and housekeeping departments. This committee comprised the assistants to the director of nursing service, the head nurses, the chief dietitian, and the acting executive housekeeper. The director of nursing service was an ex officio member. The group elected its own chairman and appointed one of the members a recorder of minutes.

To review the progress and developments of the working committee and to approve and put into operation the changes proposed, an administrative committee was organized at the hospital. This committee served as liaison between the working committee and the executive committee at the headquarters office of the Division of Hospitals in Washington, and also between the working committee and the various departments in the hospital. Periodic reports were submitted. The medical officer in charge of the hospital was the chairman of the administrative committee, the membership of which included a representative of the medical staff.

Proper orientation of members of the working committee was most important to the success of the project. The purpose of the study was clearly defined and selected references were read. The changes in the status of the professional nurse and the present

trend toward the more extensive use of nonprofessional personnel in the hospital care of the sick were discussed.

In developing a plan of procedure, the working committee found it essential to state the aims of the nursing service before proceeding. The committee then established the following premises as guides for allocating the activities:

1. The professional nurse would be responsible for all nursing care, but she could delegate some activities to nonprofessional personnel if it was adequately trained.

2. The professional nurse would give all care to the acutely ill patient.

3. Trained practical nurses, under the supervision of a professional nurse, would give all care to subacutely and chronically ill and convalescent patients, with the exception of the administration of medications and other activities involving highly skilled techniques.

4. Attendants would assist professional and practical nurses, performing specific activities for which they would be adequately trained.

Considerable time was spent discussing the different types of nursing personnel which could function in the different areas of this hospital to achieve the stated aims of the nursing service. The committee decided upon the following categories of personnel to which all nursing and related activities would be allocated:

1. Professional nurses
2. Nonprofessional
 - A. Trained practical nurses
 - B. Attendants trained on the job
3. Clerical and messenger
4. Dietary
5. Housekeeping

Because a complete list of all activities which constitute a comprehensive nursing program was not available, the committee compiled such a list to achieve the established aims of the nursing service. In allocating each activity, careful consideration was given to the factors involved in the safety of both patients and personnel, the skills required, and the educational preparation and training of each type of personnel.

Members of the committee could not always come to an immediate agreement as to which group of personnel should perform the activity under discussion. In some instances it was necessary to delay decision until the opinions of the staff nurses could be obtained. Decisions were frequently influenced by variations in standards, procedures and policies. The number of different interpretations often equaled the number of members at the meeting.

These disagreements resulted from the fact that there were no approved written routines and procedures for either the nursing or housekeeping services. Personalities and attitudes also played a part in the decisions. Members of the committee were cognizant of the

problems and deficiencies but some found it difficult to comprehend a nursing service which deviated from the status quo. Comments such as: "We have always done it this way" or "It has always been done this way here" were heard repeatedly.

Free discussion and exchange of ideas, made possible through the democratic organization of the working committee, soon changed these attitudes and very good suggestions for improving the nursing service were made by the committee. The problems, with suggestions for their solution, were referred to the administrative committee. The interest and cooperation of the members of this committee in the coordination of the activities of the departments in the hospital were a further aid to progress.

When all food service activities were allocated to the dietary department, the need for reorganization of this department became apparent. A special consultant was appointed to assist the chief dietitian in making a survey and developing a plan of reorganization.

All housekeeping activities were allocated to the housekeeping department. The acting executive housekeeper, with the aid of the working committee, formulated a plan for a housekeeping department and developed a procedure manual for use in training housekeeping personnel. This plan was approved by the administrative committee and the executive committee at headquarters. An experienced executive housekeeper was appointed as a consultant to visit the hospital and review the plan. A few minor changes were suggested and the plan was put into operation with a minimum of difficulty. Employees were transferred to this department from the nursing service and placed under the supervision and direction of the acting executive housekeeper, who is directly responsible to the medical officer in charge.

The reallocation of nursing and related activities was only one part of the development of the plan for the reorganization of the nursing service. It was necessary to determine also the numbers of the various types of employees needed and how they were to perform their activities. Procedures could not be written without first establishing the necessary hospital and medical care policies.

Additional consultants were appointed to make a complete survey of the hospital—its organization and administration, its personnel and assign-

ments, direct and indirect nursing care, the physical facilities, clinical facilities, records and reports. The report of the survey was used as a guide to develop a manual of routines and station orders, otherwise known as ward or nursing service policies. The implementation of the routines and station orders involved all other departments in the hospital. The reaction to change on the part of personnel in these areas was similar to that of the nurses. All soon became aware of the values inherent in the proposed changes to improve patient care.

When the working committee completed the reallocation of all nursing and related activities, the next step was to determine how each procedure should be performed. The identical group (the working committee) was reappointed as a committee on nursing procedures, with one of the assistants to the director of nursing service as chairman. This part of the project also required many hours of committee work. Each committee member was given an assignment to report in writing on certain procedures as they were then performed. These were presented for round table discussion and final decision. Because of the variation in the technics in use it was frequently difficult for members of the committee to reach agreement. To facilitate progress, the chairman wrote preliminary drafts of the procedures and presented copies for discussion at committee meetings. In due time a complete manual of nursing procedures was compiled by the committee.

The cost of the combined nursing and housekeeping service was determined. This and the report of the survey were used to establish a baseline for the evaluation of the effects of the proposed reorganization upon the quality of patient care and the cost of personal services.

When the study was completed, a plan was developed for the reorganization of the nursing service. The first phase of the plan has given us the answers to five of the questions previously listed. The remaining two questions will be answered when the second and third phases are implemented.

FIRST PHASE

The following have been accomplished:

The nursing and housekeeping services are segregated and a separate housekeeping department has been created.

Head nurse units have been established.

Professional nurses and attendants are now reassigned to perform the activities as allocated.

Six ward clerks were appointed to the staff and given an on-the-job course of instruction in the performance of the duties that were allocated to this group.

Additional appointments have been made in the patients' clothes room so that all checking of clothing for incoming and outgoing patients is done in this unit rather than on the wards.

A central sterile supply room is operating.

The messenger service has been expanded.

By means of in-service staff education programs, professional nurses and attendants were taught how to carry out the revised nursing procedures, and head nurses and a selected group of staff nurses were given a thirty-hour course in ward management and supervision.

As necessary supplies and equipment became available, the revised procedures were put into practice.

A clerk-stenographer was appointed in the nursing office to perform routine clerical duties, thus relieving the assistants to the director of nursing service of these activities.

Three of the assistants to the director were assigned as supervisors, each responsible for a specified area in the hospital.

The need for changes in the physical plant and the lack of funds for additional personnel have delayed putting the plan for the reorganization of the dietary department into operation. In the interval, the nurses are continuing to be responsible for the food service on the wards. The dietary department's responsibility is terminated when the food is sent to the wards. Nursing service employees place the food on the trays and carry the trays to and from the patients. In the reorganization plan, dietary department personnel will be responsible for complete preparation of all trays, and nursing service personnel will take them to and from the patients.

Evaluations of changes in the quality of the nursing service have been made. Observations indicate improvements in patient care and more efficient utilization of the time of all nursing service personnel. Professional nurses, however, are still performing some non-professional activities.

SECOND PHASE

In the second stage of the plan, trained practical nurses will be appointed to the staff. Practical nurses (graduates of approved schools who qualify for federal Civil Service appointment) will be recruited to fill vacancies created by resignations and transfers of professional nurses. These replacements will be made gradually until the maximum number has been appointed. This number will depend upon the effects of the utilization of practical nurses on the quality of the nursing service. Since there are at present no established criteria for determining the ratio of professional nurses to trained practical nurses, the maximum number which can be used will be determined by periodic evaluation of the standards of nursing care.

THIRD PHASE

When a safe and desirable ratio of professional and practical nurses has been established and all nursing service and related personnel is performing satisfactorily the activities as allocated, the cost of the nursing service will be determined and the third step will be taken. All but the tuberculous and the eye, ear, nose and throat patients will be segregated according to activity status rather than clinical service. The bed patients, the semiambulatory and the fully ambulatory patients will be placed in specified areas in the hospital.

Insofar as possible, medical and surgical patients will be segregated. Doctors on the respective services will have office hours at specified times and all ambulatory patients will go to the doctor's office rather than have the doctor visit them at the bedside. It should be noted that obstetric and pediatric patients are not admitted to this hospital.

The professional nurses will be reassigned, with a proportionately larger number assigned to the units for bed patients or those requiring more highly skilled nursing care. It is believed that the total number of professional nurses required to give good nursing care will be lessened.

Following a reasonable period of trial, the quality of the nursing service will be reevaluated and the cost of the service will be determined. The most economical plan will be continued in the hospital in which the study was made and will be used as a pattern for the reorganization of the nursing and related services in all Public Health Service hospitals.

The manuals of nursing procedures and ward policies have been prepared in loose-leaf form, for easy replacement of pages when revisions are indicated. A copy of the "Manual of Nursing Procedures" has been forwarded to every hospital in the service with instructions that it be used as a guide in the development of a similar manual for each station. It was proposed that

the adaptation of the procedures and development of a manual of procedures for each hospital be made a part of the in-service staff education programs. Suggestions were given for a plan to be followed. Standardization of procedures for all Public Health Service hospitals is desirable but not completely possible at this time because of the differences in physical plants.

Children Make Good Friends

ELIZABETH STEWART

Administrative Dietitian, Good Samaritan Hospital, Portland, Ore.

I MADE the Santa Claus on my daddy's Christmas Day tray—I know from the way I pasted it."

"My aunt works at the hospital."

"My friend, Johnnie, broke his leg and the doctor took him to Good Samaritan Hospital."

The preceding snatches of conversation were made by children and reported to us by one of the teachers at Couch Grammar School. The fifth grade pupils at this grammar school, a few blocks away, help us to prepare tray favors each year for the major holidays. The dietary department makes the drawings on 9 by 12 colored construction paper which are then taken to the children to be cut, pasted and colored. To describe a few: a Thanksgiving turkey menu cut-out is prepared by the department on brown and red paper. The children cut out and paste the pieces together to form an attractive menu. Another feature on the tray is an autumn leaf which is cut out and pasted under a soufflé cup to make an interesting bonbon favor.

The Easter tray design attracts a great deal of attention. The bunny menu card is prepared, which the children cut out, and cotton is pasted on the bunny's tail. As their own idea and contribution, they make small baskets with cutout paper flowers to hang on the forepaws.

The big thrill comes at Christmas—the children cut out a red paper Santa Claus and paste cotton to form the fur on the cap and to make his

beard. They also construct a bonbon cup out of a green holly leaf design, attached to a soufflé cup.

During the time that the children are at work in their classrooms the room teacher is talking to them regarding the work done in hospitals, and the place of the hospital in the community. Frequently, the staff dietitian who takes the supplies to the room is asked to give an informal talk on normal nutrition. The room teacher encourages discussion among the groups. The cleanliness of hands and person is also stressed, because the children must be immaculate to work on decorations going to the hospital.

THEY ALL WANT TO COME

After the work is completed, excitement reigns during the time the several boys and girls are chosen to bring the decorations back to the hospital; they all want to come! When the children arrive at the hospital they are usually shown the main kitchen and taken to the cafeteria for ice cream and cookies.

The children do relate their projects to their families, but, best of all, this experience is lessening fear of hospitals and teaching the child that the hospital is happy and friendly. He knows. Why, he worked hard making a menu card so that some ill person would be made happier. The experience also brings to his mind that the hospital, that big brick building up the street, is where people are made well!

People in Pictures

Some participants in the Indiana University workshop on "Nursing for the Future," the report made by Esther Lucile Brown. From left to right: Thelma Brittingham, acting director, Protestant Deaconess Hospital School of Nursing, Evansville, Ind.; Marian Roberts, assistant director, Indiana University Training School for Nurses; Sister Vincentiana, president, Indiana Hospital Association, LaFayette, Ind.; Mrs. Zilpha Miller Burnett, director, Good Samaritan Hospital School of Nursing, Vincennes, Ind.; J. W. Micks, chief accountant, Indiana University.



Compulsory national health insurance was discussed from all angles on a radio forum, "What's on Your Mind?" Debaters were (l. to r.) E. A. van Steenwyk, Philadelphia Blue Cross director, and Dr. Morris Fishbein, who are opposed to compulsory health insurance, and Dr. Ernest P. Boas, chairman of the Physicians Forum, and Albert Deutsch, science writer, in favor. At the center of the table is moderator Delbert Clark of the New York "Times."

The trustees of Highland Park Hospital, Highland Park, Ill., have started a series of "fireside" meetings, held at the home of a member, to which people in the community are invited to discuss various problems affecting hospitals. At a recent one, Everett W. Jones, vice president, The Modern Hospital Publishing Company, Inc., discussed socialized medicine. Trustees and guests are enthusiastic about the meetings which help to clear up misunderstandings about hospital care which arise in the minds of lay people.



A luncheon and fashion show at Cameo House restaurant served to introduce the new Women's Benefit Guild of Women's and Children's Hospital, Chicago, to members of the staff, trustees and allied organizations. Left: Nellie McNamera, president of the board, with guest Mrs. Katharine Agar. Right: Mrs. Walter E. Kraft, chairman of the committee, facing the camera, as fashion model comes down aisle.



VOLUNTARY PLANS CAN DO THE JOB

E. A. VAN STEENWYK

Director
Associated Hospital Service
Philadelphia

THE public wants the best health service that is obtainable for everyone. It wants a convenient way of paying for this service, it wants the peaks of sickness expenses removed, and it wants the cost to be moderate. These reasonable aims have already been achieved by 33,000,000 Americans through our nonprofit voluntary Blue Cross plans. In addition, 22,000,000 other Americans—55,000,000 in all—are protected against the expense of hospital care through union labor or commercial insurance plans. Additional millions, most of whom would be in the foregoing total, are protected against surgical and medical expenses. Expanding the benefits of the plans and the coverage to every American is not only possible but within short-range grasp—through local voluntary efforts coordinated in a nationwide program.

That there are unmet health needs is admitted. That there are areas requiring change in methods of providing health services is also admitted. That voluntary health insurance cannot by itself do the whole job is admitted. But much is being done about these inadequacies. One of the most thoughtful and effective federal programs intended to meet local health needs—that administered under the Hospital Construction Act—was inspired and vigorously supported by those who have advocated voluntary health insurance.

MUST SEEK BEST METHODS

Inasmuch as there is agreement on broad goals, the question narrows down to determining the best methods of making health services available to all. The record of nonprofit voluntary health insurance indicates that its extension and supplementation are practical, and that this course will provide more care for American people for less cost than will any other method. Why, when Blue Cross and Blue Shield are steadily gaining and when fulfillment of the purposes of a great voluntary system is within the grasp of American people, should our emphasis now shift to a compulsory system? Why revert now from a system which has come through its try-out period to another, untried, method which carries with it the danger of upsetting the medical

resources of the nation? The assumptions that a compulsory health insurance plan will correct inadequacies in health facilities and personnel and raise the health level of America are at best misleading. At worst, these are political promises that can only spell tragedy for the nation's health.

If the methods of providing a high level of health services for all were not complex, a federal program would probably have been voted by the American public long ago. One of the problems which causes most concern to professional workers in the health field and has some of the most baffling overtones—the maintenance of a personal relationship between doctor and patient—is also far better understood by John Public than professionals usually credit him with understanding.

Health services are personal services, from one human being to another human being. However imbued with the sense of public service government personnel may be, the three types of medical care which have been traditionally provided by local and federal governments in America, to mental patients, to the tuberculous and to the veterans, illustrate the limitation created by governmental responsibility for such personal service. This is not because government employees are not touched by the needs of the sick or are unwilling to assist them. The testimony is uniform from all who have been engaged in this work that: (1) the necessary slowness of prudent government administration impedes delivery of a satisfactory level of personal service to the individual, and (2) the uncertainties in any political system make it extremely difficult to get and keep

good doctors and other needed personnel. *The assurance being given by spokesmen for compulsory federal insurance that hospitals will not be taken over by the government and that doctors and other health personnel will not become employees of the government is fantastic. There is no other way to make such a system work.*

RELY ON LOCAL COOPERATION

The advocates of federal compulsory health insurance point to inadequacies in the voluntary health system of serving the sick in certain individual cases and in certain remote areas and, because of these inadequacies, claim that all hospital service and all medical service should be provided through the federal government. Yet the most thoughtful and effective federal government programs have relied on local cooperation. Compulsory federal health insurance would make such cooperative ventures no longer possible. One does not cooperate with the boss. The boss exercises his will. And this could not be otherwise, since under so complicated a system as compulsory health insurance on a national basis would require, responsibility could not properly rest on the federal government without complete control.

Blue Cross and Blue Shield plans have sometimes been compared with similar voluntary agencies in other countries, agencies which have given way to a compulsory government system. Sometimes these plans have been likened to the Friendly Societies in England, yet the whole scheme of organization of America's nonprofit plans is so different from that of the Friendly Societies, and their performance so

vastly superior in breadth of coverage and in health service significance to the people, that they are not in any way comparable.

Where health service inadequacies are due to the poverty of the local community or state, federal assistance may be necessary. The most important lack, adequate facilities, is now being successfully met and could be extended on a local-federal cooperative basis through the Hospital Construction Act. It is suggested that (1) *Congress be urged to increase the amount of money available to local communities under the Hospital Construction Act.* It is suggested that (2) *the collateral shortage of well trained health personnel should be met by giving federal assistance where necessary to schools and hospitals training doctors and nurses.*

America has developed a unique voluntary health insurance system. Never before has anything like the number of persons covered or the standards of performance of Blue Cross and Blue Shield been developed. These plans are operated under special enabling laws of the states in which they are organized as nonprofit corporations, and fully meet all the requirements set down by the regulatory legislation as well as more severe standards established by the plans themselves.

NOT EXTENSION OF BLUE CROSS

Many persons think mistakenly of federal compulsory health insurance as but an extension of Blue Cross, and favor it for this reason. But Blue Cross standards are high because they are a blending of all local forces—the buyers as well as the sellers of health services. This quality, so apparent in Blue Cross, would not be possible under a compulsory federal scheme. Voluntary plans help to maintain a free market in which the subscriber goes to the hospital or doctor of his choice. The individual hospital or doctor is paid because such choices have been made by people in the ordinary way. A compulsory federal insurance scheme would destroy the free market.

Yet federal assistance is needed if all the health problems of the nation are to be met. It is therefore suggested that (3) *local Hospital and Medical Authorities be created*, the geographic areas covered by each such Authority being the same as the hospital areas now being planned as a result of state surveys conducted under the Hospital Construction Act. These areas have been determined with a view to estab-

lishing facilities so that all Americans will have the advantage of the best medical care, yet costly duplication and inefficiency will be avoided.

It is suggested that (4) *grants-in-aid for the indigent be made to the states by the federal government.* Such grants-in-aid, in addition to local and state funds now spent for the care of the indigent, would be administered by the local Authorities within each state.

Since the chief problem appears to be provision of care to the indigent on a self-respecting basis, it is further suggested that (5) *the Blue Cross plan in each such Authority issue Blue Cross cards to all who are certified as indigent by the Authority.* In this way the indignity of a means test would be avoided at the time care is needed. Provision should be made for the issuance of such Blue Cross cards from year to year. Assurance would be given to everyone that regardless of ability to pay all would be entitled to the same hospital service and everyone would be given the opportunity to choose his own hospital.

Following the admission of each such indigent patient to a hospital, Blue Cross would accept liability for payment in the same manner that it now does for its regular subscribers. The bills would be paid by Blue Cross at the rate it regularly pays its member hospitals. It would then bill the Hospital Authority for the amount it has paid the hospital plus such reasonable administrative expenses as may be agreed upon.

The problem of developing incentives which will encourage individual citizens and hospitals to pull their own weight in the matter of providing health services is difficult and complex. Little good can come of any system which encourages people to sit back and rely solely upon government. To this end some thought might well be given to the possibility that income tax credits be allowed to those who pay subscription fees to Blue Cross or other health insurance plans which meet standards established by local Authorities.

Similarly, some incentive for maintaining reasonable cost levels in hospitals is necessary, since the method of hospital payment for care rendered to Blue Cross subscribers will vary with the needs and characteristics of the localities served. It would appear that the incentives to maintain reasonable cost levels must be worked out in each such Authority.

While this is a revolutionary approach to the matter of providing for the indigent, it requires a far less drastic change of our medical care program than that contemplated under federal compulsory health insurance, and it would conserve all that is good and useful in American medicine. Indeed, it is possible that out of such a program the reasonable aim of all public health workers, to blend private and governmental planning at the local level, would naturally develop. The existence of hospital councils, medical societies and other health units in addition to state and local departments of health makes an immediate approach to the establishment of the proposed Hospital Authorities possible.

ENCOURAGE VOLUNTARY PLANS

Since an important by-product of voluntary, nonprofit hospital and medical insurance is the maintenance of a free market relationship among patients, hospitals and doctors in which none can gain except through the exercise of choice or will on the part of the others, and since this system has thus far produced the highest level of health for any nation of comparable size and diversity of area and population, it would appear that the voluntary plans should be encouraged to meet the nation's needs. It is therefore also suggested that (6) *the federal government could assist the voluntary, nonprofit plans in a significant and far-reaching manner if it would grant pay roll deduction to its employees who desire to buy this coverage.* With so many federal spokesmen arguing for compulsory health insurance, it is ironic that Uncle Sam is the only national employer who will not assume the responsibility of pay roll deduction for his employees.

Voluntary nonprofit health insurance plans can offer more at lower costs to the citizen who will pay the bill under any system that is set up. To devise methods of payment to hospitals and doctors which will be fair, which will strengthen and maintain high standards, yet not become burdensome to the citizen paying the bill, will require study of the special economies and efficiencies that can be developed in local organizations.

With the help of business and labor, and the encouragement and assistance of the federal government, all that America needs and wants in better health services can be obtained through the Blue Cross and Blue Shield plans.

REFUSE and WASTE

pose no problem in disposal

DISPOSAL of hospital wastes presents no particular problem, a survey of the methods used in a group of small hospitals reveals. Commonly, wastes are collected in cans on hospital floors then carried or carted, usually by the janitor, to a central disposal point and either burned in the hospital incinerator or picked up by a city collection service.

The survey, which covered twenty-three hospitals ranging from twelve to 125 beds, disclosed few departures from this standard procedure. For example, the only hospital not using galvanized iron cans or steel drums for waste collection was a twelve-bed hospital in the South where wastes are collected in a sack by the maid.

The number of times a day that floor wastes are collected varies from one to three in the reporting hospitals. The collection is made once a day in six hospitals, twice a day in ten hospitals, and three times in five hospitals.

The responsibility for waste collection is generally carried by the house-keeping department, with the janitor, porter or orderly actually doing the collecting. In three cases a maid handles this duty, and in one case it was indicated that floor nurses may also share this duty with the maid.

About half the reporting hospitals indicated that cans are carried by hand from the floor to the elevator and thence to the collection or disposal point in the service department. In other cases either a hand truck or wheel cart is used.

Only six of the hospitals in this group do not burn their own wastes, at least in part. In most of these cases a city collection service picks up hospital refuse. In one case the hospital pays a commercial scavenger for this service. Among the hospitals burning dry wastes in their own incinerators, about half reported that the incinerator used was built and installed by a company specializing in this type of construction. Of eighteen hospitals that incinerate some waste, seven are using incinerators connected with the central boiler plant smoke stack; the others have incinerators with separate stacks. Seven of these incinerators are equipped with auxiliary firing equipment, it was indicated.

Commenting on the whole subject of waste collection and disposal in

the small hospital, one administrator said, "No matter what method is used, supervision must be strict, constant and centralized. For this reason it is advisable to have the same carefully trained houseman or janitor assigned regularly to waste pick up."

"Of course, the time schedule must depend entirely on local conditions, such as elevator capacity, storage space and other factors. You can't roll cans or carts at night because the patients are asleep. You can't do it by day because the patients are awake! So are doctors and visitors, none of whom likes the idea or appearance of waste pick up. Yet it must be picked up and the unpleasant or inconvenient factors must be dealt with in the best way that local conditions permit."

The survey dealt largely with dry wastes collected on floors. Special waste and refuse problems in addition to kitchen wastes and garbage, which were covered in a separate survey last month, require special handling according to local conditions, it is indicated. For example, placental tissues, bone tissue from amputations, and wastes from the morgue must be

burned at a temperature equal to or in excess of that used in incinerating kitchen garbage, if these wastes are dealt with on the hospital premises. It is pointed out by administrators who commented on this subject that consultation and constant checking with the operating room and delivery room supervisors will greatly facilitate the problem of handling their wastes efficiently since, obviously, no hard and fast schedule can cover all emergencies.

Another special waste disposal problem concerns the handling of discarded plaster casts. Because of the size, weight and rigidity of these materials they frequently require individual collection and disposal. "Cutting large body casts to reduce size and weight is helpful," one observer commented. "Often this can be worked out with the nursing department which usually employs the orderlies who are handling this material at the time of its removal from the patient."

Another disposal problem in most hospitals is presented by tin cans and other metal containers. The question of whether or not it pays to flatten and package tin cans may have a dif-

WASTE DISPOSAL METHODS IN SMALL HOSPITALS

REGION	BEDS	COLLECTION		TIMES DAILY	PERSONNEL	TRANSPORTATION	WASTE		HOW DISPOSED
		METHOD					INCINERATED		
East	25	Cans	2	Janitor	Cart	Yes	—		
East	75	Cans	3	Janitor	Hand	Yes	—		
East	85	Cans	2	Janitor	Cart	Part	City		
East	75	Cans	3	Janitor	Truck	No	Scavenger		
Midwest	25	Cans	1	Janitor	Hand	Yes	—		
Midwest	70	—	2	Janitor	—	Yes	—		
Midwest	75	Cans	3	Janitor	Hand	Yes	—		
Midwest	125	—	3	Janitor	Hand	Yes	—		
Midwest	72	Cans	3	Janitor	Cart	No	—		
Midwest	94	Cans	1	Janitor	Hand	Yes	—		
Midwest	30	Cans	2	Janitor	Hand	Yes	—		
South	90	Cans	1	Janitor	Hand	No	City		
South	56	Cans	2	Orderly	Truck	No	City		
South	58	Cans	1	—	Hand	Yes	—		
South	53	Cans	2	Janitor	Cart	No	City		
South	110	Cans	1	Janitor	Truck	Yes	—		
South	12	Bag	1	Maid	Hand	Part	City		
South	56	Cans	2	Maid	Hand	No	City		
South	66	Chute	—	Maid	Chute	Yes	—		
South	119	Cans	2	Porter	Truck	Yes	—		
West	82	Cans	2	Janitor	Truck	Yes	—		
West	30	Cans	—	Janitor	Hand	Part	City		
West	100	Cans	2	Porter	Hand	Yes	—		

ferent answer in different communities. At present it is indicated the price of baled tin makes the salvage of this material worth while.

Disposal of glass also requires special handling. Increased use of glass

containers not readily adaptable for reuse makes this a growing problem. "Glass apparently has no salvage value outside one's own reuse," it was pointed out by one respondent. "It is bulky to store, can do damage to the careless

handler, and is generally a nuisance. Certain kinds of containers can be smashed to conserve space, other types are discarded as is. Trucking to a city dump is the usual method of disposing of glass wastes."

ARE CONTROL SYSTEMS WORTH THE EFFORT?

ROBERT E. SLEIGHT

Special Assistant
to the Controller
Memorial Hospital
New York City

SUPPLIES used in the hospital constitute one of the largest expense items. Adequate controls may help to keep this cost within reason.

Internal control of hospital supplies means the accounting or perpetual inventory system used by the institution to maintain a thorough check on the purchasing, receiving, storing and issuing of its standardized items.

There should be a stock record card for each item showing: (1) the quantity on hand, (2) the quantity on order, (3) the quantity issued to each department, (4) the company from which the supplies were purchased, and (5) the unit cost. These data may be recorded on one or more cards and may be kept in many different ways. The order and stock record forms shown in the accompanying illustration are used in pairs and the stores inventory record is used singly. These two arrangements are typical illustrations of good stock record cards.

No system of internal control can be appraised until all are willing to concede that standardization of supplies is essential. It is clerically impossible to maintain stock record cards unless each card consistently represents only one specific item.

Why should the problem of internal control be considered? With a standard type of supply it will be easy to make replacements and to store and to issue items, because everyone involved will know what to expect. Thus, the staff will be able to function more effectively. Supplies should cost less than they do when each department uses a different type of item. And the demand should be met quickly, as forecasts can be made which should ensure adequate stocks on hand.

Any possible means of reducing costs and improving service should be studied. An inventory or internal control system offers such a possibility.

There are many reasons why such a system is desirable. When preparing a budget estimate one must rely upon past activities. In order to make this sound forecast, the monthly perpetual inventory reports, compiled from the stock record cards and the month's requisitions, afford the best available and most nearly accurate figures.

One of the largest expense items is that of surgical dressings. A medium sized surgical hospital may use more than \$5000 worth a month. Such a dollar volume is important when the administrator is considering his budget for the central surgical supply room or the cost of patient care.

Perpetual inventory records furnish data for administrative control. A check can be made to see that the purchasing agent is doing a good job. Is he getting good deliveries, are his prices low, and is his quality "tops"?

Is the storekeeper doing a good job by keeping adequate stocks, by eliminating obsolete items, and by not overstocking?

How well is the receiving clerk doing his job? Is the time lag reasonable for supplies reaching the stockroom from the receiving room? Are the quantities the same when the supplies reach the stockroom as they were when they left the receiving room?

Is the accounts payable clerk getting all the discounts he should by prompt payment of invoices? If not, who is causing the delay and loss? Are the invoices correct?

Is the stock control clerk on his toes? Are his postings up to date and are they accurate? This can be determined by rotating and or spot inventories. Is he calling the attention of the administrator or his assistant to major differ-

ences? A major difference might be one drum of floor wax costing \$162 or a substantial shortage of bars of hand soap costing \$0.01 each.

All of these questions could be answered from a good stock record system. The order and stock record cards would serve this purpose very well.

Internal controls furnish records for administrative research. Savings can be made by avoiding duplication and waste by specific personnel or departments. Studies can be made whereby two items can be replaced by one, thus simplifying the supply problem. Such was the case when a 1000 bed general hospital eliminated the 8 by 10 inch dressing and substituted the 8 by 8 inch size—the 8 by 8 being one of the regularly stocked items. Of course, the medical staff agreed to this change. An estimated saving of more than \$1200 is expected the first year.

One 250 bed hospital used 127 pairs of overalls in six months, costing \$495. Inasmuch as only twelve men in the engineering department used hospital overalls, the quantity seemed abnormally large. It was discovered that there had been a large turnover in labor. Each man had taken his pair with him when he quit. This practice was stopped by requiring each man to deposit \$3 when he drew his set.

The records would show which supplies are increasing or decreasing in use and would enable the storage facilities and personnel requirements to be appropriately adjusted. It is needlessly expensive to buy in small lots or to require consistent overtime of employees. And it is wasteful to have more than the necessary space allocated to the stockroom. However, hospitals generally don't have to worry about too much space; they are usually too short of all types of room. Thus, the space adjustments would usually have to be made within the stockroom itself by

rearranging the various items so as to provide properly for each item carried in stock.

These records would show how new items are being used and, thereby, would give an indication as to their acceptability. The cards would show who is using it, in what volume, and at what cost.

This might apply to groups of items as well as to single items. For instance, a new pathology research grant was provided by a national institute. Accurate cost figures were required so that future requests could be supported in detail and so that current expenses could be kept within the grant's limits. The first month the cost for supplies was \$309—considerably over the monthly allotment. By using a cheaper type of cover-glass—one of the more important items required—the figure was reduced to less than \$200.

The reputation of the hospital is most important if its future service is to be of the highest standard. A good community reputation helps to attract the better type of trustee and doctor, better and more volunteers, and more money. Dishonesty is discouraged by making it difficult to steal. Major thefts will be discovered and traced and minor thefts will be reduced by any good internal control system.

On the other hand, there are several reasons why internal controls are undesirable. The cost may exceed the saving. For instance, one medium sized hospital had seventy-two postings per month for penpoints valued at \$6.21 and forty-six postings per month for rubber bands valued at \$2.65. It is questionable whether the time spent was worth the records maintained.

Personnel must be employed, supplies are required, and space must be available if any type of control is to be instituted. All these cost money and may be expensive.

It is practically impossible to eliminate stealing in a hospital. Many employees take things routinely—usually small items. Often the employees do not consider it stealing but as part of their compensation in view of their low pay. Towels, sheets, paper, pencils, soap, small instruments, adhesive tape, and drugs are some of the many items that are expended via the front or rear doors. It is difficult, if not impossible, to keep track of such items—especially when they are used briefly by many people.

Any control system requires extra work and might slow down the flow of supplies. The system might lead to excessive red tape and complicate the hospital's operation.

Often the doctors do not like controls. They are usually extremely busy with their patients and may not be interested. Thus, the administrator must educate them.

Some hospitals use standardization committees composed of the chiefs of services, the purchasing agent, and the administrator. This is a sound system if the doctors cooperate. One 1200 bed hospital has had considerable success while a 250 bed hospital, in the same area, has not been successful with such standardization committees.

Any administrative system in a hospital is confronted with the problem of the unstable nurse. Because many of the nurses change jobs frequently, a tight control system is difficult to operate. This is true because each institution has a different procedure. Also, the nurses are extremely busy and often are not interested. Thus, the administrator has another educational job.

Are internal controls of hospital supplies desirable? Having developed the reasons for considering the question and having stated the various advantages and disadvantages, the following three conclusions must be drawn:

First, some type of internal control should be provided. The size of the hospital will determine the kind of procedure to be used. A small institution might have several jobs grouped together and employ a simple paper system. A large institution might have separate departments for the various jobs, such as purchasing, stockroom, receiving, accounts payable, and stock records. Such an organization would have, of necessity, a detailed paper system.

Second, the financial condition of the hospital would be a determining factor in the type of controls installed. An institution with small income might have a manually operated system, while an institution with a more remunerative practice might have an elaborate accounting procedure—frequently using one or more of the various types of business machines available.

Third, much depends upon the particular philosophies and interests of the community. What are the community's feelings about the operation of the hospital? The hospital's prestige might have much to do with deciding the answer to this question. And the professional pressure that exists might have some bearing upon the type of system selected.

ACCOUNT NO.		P-101		STORES INVENTORY RECORD		MEMORIAL HOSPITAL		QUAN. UNIT PACKAGE		MAX STOCK 200		MIN STOCK 50		SYMBOL NO. P-101	
TRAY COVERS - PAPER - CREPE - EMBOSSED 15 x 20 (1000 to pkg)															
RECEIPTS								DISBURSEMENTS							
DATE	ORDER NO.	DEALER	QUAN.	UNIT COST	TOTAL COST	DATE	ACCOUNT	QUAN.	STOCK BAL.	COST	COST BAL.				
11-2-48	7691	Star Paper Co.	100	3.75	375.00	10-10-48	Forward balance	59							
						10-23	588 - 66	1	58						
						10-27	723 - 75	1	57						
						10-28	792 - 45	4	53						
						11-3	P1356	100	153						
STOCK RECORD - MEMORIAL HOSPITAL															
ITEM P-101 PKG. TRAY COVERS - PAPER - CREPE - EMBOSSED 15 x 20 (1000 to pkg) bin 2A															
QUANTITY						QUANTITY									
DATE	NUMBER	DEPT NO.	RECEIVED	ISSUED	BALANCE	DATE	NUMBER	DEPT NO.	RECEIVED	ISSUED	BALANCE				
10-10-48	Forward balance				59										
10-23	588	66		1	58										
10-27	723	75			57										
10-28	792	45		4	53										
11-3	P1356		100		153										
ORDER RECORD															
MEMORIAL HOSPITAL															
ITEM P-101 PKG. TRAY COVERS - PAPER - CREPE - EMBOSSED 15 x 20 (1000 to pkg)															
ORDERED						RECEIVED						COST			
PURCHASE REQUEST DATE	NUMBER	DATE	QUANTITY	VENDOR		NUMBER	DATE	QUANTITY	UNIT	TOTAL					
11-1-48	7691	11-2-48	100	Star Paper Company		P1356	11-3-48	100	3.75	375.00					

About People

Administrators

Arkell B. Cook, administrator of Garfield Memorial Hospital, Washington, D. C., has been appointed administrator of Evanston Hospital, Evanston, Ill., succeeding **Dr. Roger W. DeBusk**. Before his appointment at Garfield Memorial Hospital, Mr. Cook was superintendent of Monmouth Memorial Hospital at Long Branch, N. J. Prior to that he was assistant director of the University Hospital, Ann Arbor, Mich. Mr. Cook is a personal member of the American Hospital Association and a member of the American College of Hospital Administrators.



A. B. Cook

Roland G. Eaton took over the duties of business manager of Rochester General Hospital, Rochester, N. Y., on January 1. Mr. Eaton has been engaged in hotel operation most of his business life. During World War II he served in the navy, attaining the rank of lieutenant commander in naval intelligence.

J. K. Owen has been made assistant director of the hospital division of the Medical College of Virginia. He was formerly administrative assistant to the director of the division.

H. W. Burtress is the new administrator of Lutheran Deaconess Hospital, Chicago, succeeding **E. E. Hanson**, who retired last fall.

Raymond A. Baldwin has been appointed administrator of Beebe Hospital of Sussex County at Lewes, Del. Mr. Baldwin was formerly with Memorial Hospital, Cumberland, Md.

Ruth Cole, R.N., is the new superintendent of Miner's Hospital, Christopher, Ill.

Norman Bailey, formerly personnel director of Michael Reese Hospital, Chicago, and assistant administrator of Lenox Hill Hospital, New York City, has been appointed administrator of Knickerbocker Hospital, New York City.

Sister M. Milburgis succeeded **Sister M. Henrica** on her retirement as administrator of St. Joseph's Hospital, Joliet, Ill.

Joseph H. Faith has succeeded **George A. Lindsley** as manager of the John and Mary E. Kirby Hospital in Monticello, Ill. Mr. Lindsley has been appointed hospital consultant in the division of hospital construction and services, Illinois Department of Public Health.

Harry C. F. Gifford, formerly assistant to the superintendent, Hackensack Hospital, Hackensack, N. J., has been appointed superintendent of North Country Community Hospital, Glen Cove, N. Y. Mr. Gifford is a graduate of the course in hospital administration, School of Public Health, Columbia University, having served his administrative internship at the Greenwich Hospital at Greenwich, Conn.

Dr. Louis Belinson has been appointed acting superintendent of Dixon State Hospital, Dixon, Ill. He is filling the vacancy caused by the recent death of **Dr. Warren G. Murray**, who had been superintendent of the institution for more than twenty-six years.

Mrs. Margaret Krueger is the new superintendent of Shelby County Hospital, Shelbyville, Ill.

George B. Pearson completed his residency and assistantship at Harris Memorial Hospital, Fort Worth, Tex., and is now administrator of Highland Hospital, Shreveport, La. He is a graduate of the Northwestern University course in hospital administration.

Charles W. Davidson and **Robin C. Buerki Jr.** have been appointed assistant directors, St. Luke's Hospital, New York City. Mr. Davidson has been comptroller of the institution during the last three years, and since 1942 Mr. Buerki, as administrative assistant, has been concerned chiefly with the hospital's maintenance and service departments.



Robin C. Buerki Jr.



C. W. Davidson

Dr. S. S. Rooth has replaced **Dr. M. L. Busch** as administrator of Edgewater Hospital, Chicago. Dr. Busch is now superintendent of Mission Hospital, Huntington Park, Calif.

Mary Zembko, formerly acting business manager of Overlook Hospital, Summit, N. J., has been named business manager. At the same time it was announced that **Ellen Whitmore** has advanced from assistant purchasing agent to purchasing agent, and **Ann Gambardella**, purchasing agent and secretary to the director for two years, is now executive assistant and secretary to the director.

Dr. Benjamin W. Mandelstam has been appointed executive director of the Nathan Littauer Hospital, Gloversville, N. Y., succeeding **Mrs. Jennie Walker Denham**, who resigned.



Dr. Mandelstam was assistant director at Boston's Beth Israel Hospital for two years; prior to that he was assistant director at Jewish Hospital of Brooklyn. He assumed his new duties February 15.

Doris R. Sherman, R.N., formerly director of nurses at Pekin Public Hospital, Pekin, Ill., has been named superintendent of the hospital.

Sister M. Therese, O.S.F., has been appointed administrator of St. Francis Hospital, Peoria, Ill. She succeeds **Sister M. Ancilla**, who served the hospital as administrator for nine years.

Harold A. Sayles has resigned as superintendent of University Hospital, Baltimore, to become superintendent of Harris Hospital, Fort Worth, Tex.

Lawrence Brett is now administrator of Lexington Memorial Hospital, Lexington, N. C. He was formerly with Watts Hospital, Durham, N. C.

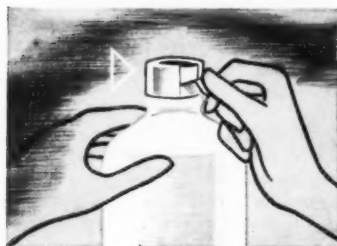
G. Nelson Watts has resigned as assistant administrator and controller of Alexandria Hospital, Alexandria, Va., to accept the position of administrative assistant of Wilmington General Hospital, Wilmington, Del.

(Continued on Page 184.)

3

SAFE, SIMPLE STEPS

prepare
Cutter
Saftiflask
for use



1 Remove outer Saftiseal by pulling raised tear tab.

Cutter's large-sized tab permits easy removal of the tamper-proof metal Saftiseal. Cap is easily slipped off in one simple motion.



2 Lift vacuum-sealed rubber liner from lip and stopper.

Cutter's rubber liner assures a complete sterile seal. When liner is lifted, the safety signal of protective vacuum is clearly audible.



3 Insert Expendable I. V. Set into outlet hole of Saftiflask stopper.

Cutter's specially designed ring of live rubber within the stopper allows easy insertion of connecting tube and secures the tube firmly in place.

Expendable, Sterile, Pyrogen-free, Ready-to-use I. V. Set. Combine this ready-to-use disposable set with sterile, pyrogen-free Cutter Solutions in Saftiflasks for a streamlined, functional I. V. infusion set-up.

In addition to the plastic I. V. Set shown (also available with rubber tubing), Cutter's complete line of expendable equipment includes Hypodermoclysis and Y-tube sets, Blood and Plasma infusion sets, and Donor set. Cutter Laboratories, Berkeley 10, California



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SAFTIFLASKS

Ask your hospital supplier to demonstrate these time and trouble saving features of the Cutter line.

Volunteer Forum

Conducted by Raymond P. Sloan

action by the auxiliary makes

Children's Ward a Fairyland

THE story of how a group of devoted women worked for ten years to realize its dream of a pediatric ward where children would be happy though hospitalized was told recently when a new building was opened at Kenosha Hospital, Kenosha, Wis. An important unit in the new building, the children's ward was described by one observer as "a pink and blue fairyland of appealing color, sparkling glass, and storybook pictures."

The story starts ten years ago, when Mrs. R. V. Anderson of Kenosha was visiting in the children's ward of the old hospital, where she watched a child patient recover consciousness following an operation. The child—a boy who had been injured in an accident—was a stranger to her, but his agonized cry, "I want to go home!" moved her so deeply that she resolved then and there to do what she could to ease the terror of hospitalization for children.

"Something is wrong with our hospital," Mrs. Anderson told a few of her friends, recounting her experiences, "when a young boy is frightened just by the sight of a plain ward wall!" They talked it over and decided that something should be done. The five-bed ward used for children got a new coat of paint, refinished furniture, venetian blinds to replace tattered shades, and light fixtures.

The women then engaged two Kenosha art teachers to paint murals on the walls. That started them on a ten-year adventure in the psychology of color and children. The bright colored murals were too exciting for sick children, they found. And they switched from nursery rhyme characters to original murals when they discovered some children have pet hates. One tiny girl wouldn't go to sleep, for example, as long as Humpty Dumpty sat on the wall over her bed.

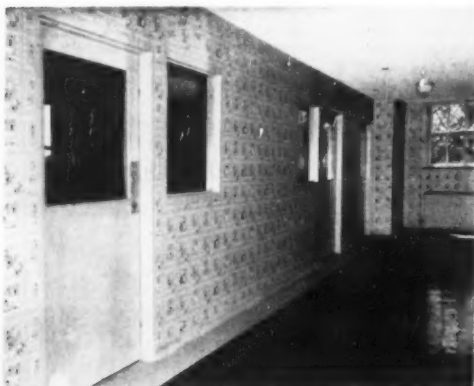
A painting of a fairy castle produced the desired result with a small boy.

"He spent all of his time imagining the many wonderful things that must be happening inside the castle," the boy's grateful mother told Mrs. Anderson and the others — Mrs. Charles Miller, Mrs. Gilbert Lance and Mrs. Lawrence Baldwin.

In 1939, Mrs. Miller and Mrs. James T. Wilson set out to form the Kenosha Hospital auxiliary. Together they signed twenty-seven charter members.

The auxiliary started a campaign for a larger and better equipped children's ward and for reconditioning of the nurses' home. They established a memorial fund to accept contributions, and they opened a small shop in the lobby to sell dolls, trinkets, toys and reading material. Proceeds went into a fund for a better children's ward.

The women pitched in during the war to help with hospital chores during



Corridor of pediatric department showing special wall covering, rubber tile floor, acoustical ceiling.



Artist Mary Voelz painting a mural of Winken, Blinken and Nod in Kenosha's new children's ward.

A Single Injection Every Other Day



Antibiotic therapy is greatly simplified when C.S.C. Crystalline Procaine Penicillin G in Peanut Oil with aluminum monostearate is prescribed. A single 1 cc. injection (300,000 units) produces therapeutic blood levels for 96 hours in over 90% of patients, and for 48 hours in all patients. For certainty of therapy, this preparation need not be given, as a rule, more often than once every other day.

Crystalline Procaine Penicillin G in Peanut Oil-C.S.C. contains 300,000 units of micronized procaine penicillin per cc., together with 2% aluminum monostearate for producing a thixotropic suspension. This outstanding penicillin preparation is free flowing and requires no refrigeration. It is indicated in the treatment of most infectious diseases amenable to penicillin therapy.

Crystalline Procaine Penicillin G in Peanut Oil-C.S.C. is available at all pharmacies in economical 10 cc. size rubber-stoppered vials (300,000 units per cc.). Also in vials containing 300,000 units (1 cc.), in boxes of five vials.

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CRYSTALLINE PROCAINE PENICILLIN G
IN PEANUT OIL
WITH 2% ALUMINUM MONOSTEARATE**

C.S.C. Pharmaceuticals

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the nurse shortage. When they made out of town trips they visited hospitals and brought back reports on the best features in other hospitals.

After the war, the women worked with Omer B. Maphis, hospital administrator, and a group of directing doctors on plans for the children's ward that was part of the new wing.

The twelve "dream world murals" in the new children's ward were painted by Mrs. Vernon Voelz and Mrs. George Pollard, Kenosha artists who have done art work for children's books.

The result, everyone hopes, will be delighted chuckles instead of terrified screams from Kenosha youngsters who awake in the new hospital ward.

The walls of the central corridor are finished with a permanent plastic material in a pattern displaying cunning peasant children on a powder-blue background. Walking down this hall, one looks through large glass panes into the rooms and wards in glowing pink, each one made lovely by a delicately colored mural. The attractive metal furniture is finished in powder blue, and sheer white curtains soften the sunlight which pours in through the huge outside windows. Bathrooms and closets are as attractive as those in a model home.

Through study, consultation with experts, and many trips taken to other hospitals, certain rules were worked out by those responsible for the decoration of the pediatric ward and these have been faithfully adhered to. Some of them are:

Walls of rooms and wards must be pink, as that color has an excellent psychological effect on sick children, making them actually look and feel healthier. Murals must not employ striking color or shade contrasts which might have a disturbing effect when viewed by a feverish child over a long period of time. Murals must not picture any familiar story-book characters, as imaginative children sometimes conceive an actual fear of one or more of them and would be frightened by a picture which would delight the average child. Murals, for the same reason, must not show any fierce wild animals.

They must also show only quiet and soothing scenes and activities—no acrobats, circus parades, running children, or other spirited action which might encourage mental or physical tension. Each must also incorporate at least one child lying down in a relaxed position (so that the nurse may point to the pictured child as an example

for her restless small patients to emulate). The eyes of no animal or character in the murals must seem to look directly at the observer (to eliminate the effect of being "stared at"). And, above all, the same kind of beauty which appeals to adults and children alike—that of color, proportion and form—must surround and comfort the child with its healing influence.

To help the hospital operate its new pediatric department, auxiliary members serve as volunteer hostesses on the children's floor—turning away visitors without permits, assisting with

the hospital gowns that are mandatory garb for all visitors to the department, and following up on rules governing termination of visits. Auxiliary members have also been helpful in explaining to parents of hospitalized children why they are not permitted to bring candy or other food and why gifts must be restricted to washable toys and books. "There is much that the visitor can do to speed or retard the rapid recovery of young patients," an auxiliary announcement said. "The special regulations protect sick children and aid their battle for health."

VOLUNTEER ACTIVITIES

Activities Are Varied

That active group, the New Rochelle League for Service, which presents annually a winter revue for the benefit of New Rochelle Hospital, New Rochelle, N.Y., has other activities besides making money. Recently it instituted a story telling hour for little patients in the department of pediatrics. From 2 to 3 o'clock every Tuesday and Thursday a league member reads stories to the children and plays records of nursery rhymes, children's tales, and songs. The record and book library is limited, and donations are being solicited locally by the league.

Playroom for Convalescents

A large playroom offers entertainment and recreation for convalescent children of various age groups in the new pediatric department of Mercy Hospital, Hamilton, Ohio. Excitement begins in the playroom at the moment the toy cart starts to move. The Junior Women's League of the hospital has equipped the cart with toys of enchanting interest to the children; there are picture and story books on the cart as well as games and individual and group toys.

The Oldest of These

Four official women's groups aid Shadyside Hospital, Pittsburgh, and the oldest of these is the Ladies' Association. Founded back in 1869, it was originally composed of twenty-four young women whose object was the welfare of charity patients. Now the group, still small (thirty-four members), is a semi-official board of managers representing community interest in the conduct of the hospital and the welfare of its patients. Members visit

and inspect the hospital regularly, report on conditions and needs, and provide many improvements.

Now the able Mrs. A. K. Oliver, who has been president of the Ladies' Association for twenty years, has given over the reins to Mrs. Thomas Watson, wife of the president of the board of trustees. The resourceful and practical Mrs. Oliver, however, has not lost interest in her pet project; today she is serving as vice president of the women's group.

Dancing School Makes Money

A successful money raising scheme is the children's dancing school in Minneapolis run by the Junior Board of Northwestern Hospital. It is now the main money raising project for the student nurse recreation fund. The dancing school, held in a community church, has classes on Mondays and Fridays from 3:30 to 4:30 for children from 4 to 6 years old, and on Fridays from 4:30 to 5:30 for children from 7 to 11.

The senior auxiliary at Northwestern recently transformed a shabby and barren recreation room for the resident staff into a good looking lounge. The room was officially opened last December with the ladies inspecting it just prior to their Silver Tea.

They Read Everything

Other hospital auxiliaries may find that foreign language books are popular as sick-bed reading. This was the discovery of an auxiliary group at Cedars of Lebanon Hospital, Los Angeles. Fiction and mysteries, of course, top the list of books requested by patients, with humorous books and magazines following.

Recognized 
FOR ITS UNUSUAL MERIT

KWELL[®] OINTMENT



THE outstanding scabidical and pediculicidal properties of Kwell Ointment were again reaffirmed in a recently reported study. Cannon and McRae¹ treated 100 cases of scabies and achieved clinical cures in all patients. Sixty-one patients required but one application, 36, two applications, and the remaining 3, three applications. Subjective relief was apparent in 2 to 3 hours in a few patients, and was complete in 24 to 48 hours in half the patients. No instance of dermatitis was observed, and no evidence of sensitivity was obtained on subsequent testing. Kwell Ointment was applied in the presence of secondary infection without adverse results; in fact, control of the infestation permitted prompt healing of the superimposed dermatitis. Equally good results were obtained in a small series of pediculosis corporis and pubis.

This outstanding performance of Kwell Ointment has been previously reported.^{2,3} Its sound clinical and experimental background merit its use whenever a diagnosis of scabies or pediculosis is made.

Kwell Ointment containing 0.5 per cent of the gamma isomer 1,2,3,4,5,6-hexachlorocyclohexane is available on prescription in 2 ounce and 1 pound jars. Literature to physicians on request.

An Outstanding Scabicide and Pediculicide

* 1. Cannon, A. Benson, and McRae, Marvin E.: Treatment of Scabies. J.A.M.A. 138:557 (Oct. 23) 1948.

2. Wooldridge, W. E.: The Gamma Isomer of Hexachlorocyclohexane in the Treatment of Scabies. J. Invest. Dermat. 10:363 (May) 1948.

3. Niedelman, M. L.: Treatment of Common Skin Diseases in Infants and Children. J. Pediat. 32:566 (May) 1948.

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Medicine and Pharmacy

Teamwork Is the Essence of Good Medical Care

DEAN A. CLARK, M.D.

Medical Director, Health Insurance Plan of Greater New York

IN GENERAL, we can accept any one of several definitions of the term group practice, all of which stress five factors: (1) there are several physicians (three or more has been suggested as a minimum number by the Public Health Service); (2) these physicians are expert in more than one special field of medicine (three orthopedists associated with each other, for instance, would not be considered a "group" in the sense meant here); (3) the physicians are systematically associated, as in a partnership or as paid members of a staff of some organization (hospital, industrial firm, labor union, cooperative); (4) income from practice is pooled and, after overhead costs, reserves and so on have been provided for, is distributed among the physicians on some basis other than solely the amounts paid to the group by the particular patients of each, and (5) the physicians use in common the professional facilities and the assisting professional, technical and clerical personnel.

GROUPS ARE OF MANY KINDS

There are many kinds of groups, for example, those which provide a general medical service as distinguished from those whose practice is mainly devoted to referred cases. Sources of income likewise vary from those supported largely by fees-for-service paid by individual patients to those chiefly dependent on a prepayment plan, an industrial or labor organization, or a health agency (official or voluntary) for their livelihood.

Condensed from a paper presented to the American Public Health Association, 1948.

The *kind* of group makes little difference here although the "kind" does affect quality of service in many subtle and important ways. It is the *group method* itself in relation to quality of care which is important. Nor are we greatly concerned with the particular administrative structure involved, whether partnership, corporation, cooperative and so on, although this, too, obviously can have great importance in considerations of quality. We shall emphasize instead the factors common to virtually all kinds of medical groups, however they make their professional living.

It seems to me that group medical practice *per se* tends toward improving the quality of medical care because of the incentives it brings about in two separate, though intimately related, areas, namely, the professional and the economic. In professional matters, the qualitative advantages of the group method arise from factors such as the following:

The individual physician has easily available to him, in a medical group, the varied skills of his medical colleagues and associated personnel. He usually has access to technical facilities, such as laboratory, x-ray and physical therapy equipment, vastly superior to what he as an individual could afford or could efficiently utilize. These associations stimulate and educate the physician as a member of a team. His specialized colleagues may be called in at a moment's notice; his daily work, in the nature of things, is constantly under the scrutiny of the other physicians of the group, senior and junior. In such circumstances, any man wants to do his best—and he expects their best from his associates.

Other professional advantages work toward the same end. A group may arrange systematically for free time for its individual members, whether for recreation or study. The young physician in a group may immediately exercise, under suitable supervision, the full range of his professional capacities instead of being obliged to wait, as is all too common in individual practice, for patients to accumulate while his hard-earned skills grow rusty.

It is thus clear that the professional influences in a medical group are an inducement to the improvement of the quality of service rendered by its physicians, individually and collectively.

In the economic area, the influences are no less conducive to our purpose. First, the group method, by its very character, makes for economies which aid rather than hinder professional quality. The ability of a group to obtain at relatively low cost to each individual physician better technical equipment and personnel than its physicians could afford separately has already been mentioned. Additional economies are achieved by the fact that this equipment and personnel can be used to greater advantage by the group than they can by an individual physician. Many a general physician, for example, has in his office costly x-ray and physical therapy equipment which he can use but a few hours each day, but in a group such equipment can be kept busy to the limit of its capacity.

NET INCOMES ARE HIGHER

Second, physicians in group practice are likely to earn, whether because of the economies achieved or some other reasons, much higher net incomes, on the average, than do those in individual practice. A recent study by *Medical Economics*, for instance, showed that in 1947 whereas physicians in solo practice received an average gross income of approximately \$18,000 and a net of \$11,000, physicians in partnership or group practice averaged \$27,000 gross and \$16,500 net.

While amounts of earning are obviously not necessarily commensurate with quality of care, the possibility of a better living would seem bound, in the long run, to aid in attracting the better trained physician to group practice. The advantages of steady income



*The dihydro
form of
streptomycin*

Dihydrostreptomycin Squibb

PERMITS HIGHER DOSAGE FOR MORE PROLONGED PERIODS

WHAT IS IT?

A potent antibiotic compound derived from streptomycin by reduction with hydrogen.

**WHEN IS IT
INDICATED?**

Like streptomycin, as an adjunct to other measures in tuberculosis.

**HOW DOES
IT ACT?**

The antibacterial activity of Dihydrostreptomycin usually parallels that of streptomycin in tuberculosis. Resistant strains of organisms appear to develop as rapidly as with streptomycin.

**WHAT ARE ITS
ADVANTAGES?**

Dihydrostreptomycin is significantly less neurotoxic than streptomycin and hence can be given in larger doses and for more prolonged periods. In addition, patients showing allergic reactions to streptomycin have been able to continue with the dihydro form.

**HOW IS IT
ADMINISTERED?**

Only intramuscularly, pending further clinical studies.

**WHAT IS THE
DOSAGE?**

Daily doses of 2 grams of Dihydrostreptomycin Squibb may be given safely for periods equal to those in which streptomycin has been restricted to 1 gram a day, provided there is no renal dysfunction. Average dosage—1 to 2 grams daily in divided doses every 12 hours.

HOW SUPPLIED?

20 cc. vials containing the equivalent of 1 Gm. streptomycin base
50 cc. vials containing the equivalent of 5 Gm. streptomycin base

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and, in many groups, of a planned retirement system are other influences of the same character.

The joy to a physician of being relieved of the tedious burdens of business management, of hiring personnel, purchasing, setting and collecting fees, offered by a medical group through its business manager, is a third advantage in the economic area which not only attracts the best type of physician but leaves him free to devote his full time and energy to his professional work.

Above all, from the standpoint of quality of care, the financial arrangements of group practice induce cooperative rather than competitive effort on the part of the physicians of a group. A healthy competitive element exists over the years, of course, in any group because each physician wants to demonstrate his value to the group as a whole and thus his right to a larger share of the proceeds—even this is a stimulant for high quality in a physician's service. But for the daily work of rendering medical services, the economic as well as the professional incentives in group practice lead toward cooperation and, therefore, improved quality.

ENCOURAGES GOOD WORK

In a group, the good work done by any individual physician reflects credit on the whole group. Discredit for the whole group obviously results likewise from any physician's poor work. Therefore, all physicians of a group, if only from purely economic motives, are constantly stimulated to do good quality work themselves and, equally important, to urge their associates to do so too.

In most existing medical groups, the physician's share of the group's net income is based upon his competence and his general value to the group as a whole. These shares are usually not determined primarily by the number of patients seen or the number of services rendered by a given physician, although such matters may be taken into account. As a result, individual physicians in a group lose no income when they refer a patient to another physician and have no financial incentive to "hold on" to a case personally. Rather, the financial interest of each physician is best served if the most thorough and satisfactory job possible is done for the patient by the group as a whole, so that the group as such may attract and keep a good clientele. Thus, the economic incentives of group practice en-

courage physicians to make use of the varied skills of their colleagues and of the group's laboratory and x-ray services for diagnosis and treatment as fully as may be medically desirable for the patient's benefit.

Such teamwork medicine is, of course, the essence of group practice and is obviously necessary to produce a high quality of care amid the complexities of modern medicine which cannot conceivably be grasped by any one physician alone. So we see that economic incentives for high quality, equally as powerful as the professional ones mentioned earlier, spring from the nature of the group method itself.

The value of group medical practice in improving the quality of medical care is not limited, however, to the positive advantages to be found within a medical group. It arises also in a negative sense from the fact that group practice, and as far as can now be ascertained only group practice, will serve to correct many of the evils apparently inherent in the individual, competitive practice of medicine on a fee-for-service basis. These evils are in large part of recent origin and do not spring primarily from any malign intent on the part of the physician as a person but rather from the same scientific advances which have made teamwork in medicine necessary and desirable.

Some of these evils have been referred to by implication in describing the advantages of group practice. The waste by duplication in individual offices of often inadequate but nevertheless costly technical equipment and associated personnel, rarely used to their full effectiveness, is one example. Another is the waste of the time and skill of the young physician in individual practice who must frequently spend much time idle before his talents can be fully utilized.

The expensive equipment and highly skilled associated personnel and the long and costly training of the young physician, all of which are in part wasted in solo practice, are, of course, necessitated by the tremendous advances in medical science. All are too precious to waste. Group practice, especially in association with better training of personnel, regional planning, and sound administration, can go far toward eliminating this waste.

But of all the evils of individual practice which the group method can eliminate, the most serious are the chaotic state of the relationships of the

general practitioner and the various types of specialists with one another and the effects of these relationships upon the care of patients. Clearly, from the patient's point of view, he should be referred to the various types of specialists and for laboratory and x-ray examinations as frequently as necessary for the management of his case according to the best standards of scientific medicine, but no more so.

Obviously, the exact optimum for such referrals is often impossible to determine in any given case but, over the long run, something very close to it can be achieved in a well organized medical group or on the wards of a teaching hospital. There is no doubt, that the optimum can be and sometimes is achieved in solo practice, especially for relatively well educated and well-to-do patients. But the barriers to a proper use of teamwork in individual practice make attainment of this goal exceedingly difficult at best.

On the one hand, the physician in isolated practice may refer his patients to others too infrequently. He may fail to use others' services, for one thing, simply because his years in solo practice have so limited the horizons of his knowledge that he does not even realize that his patient might gain from special tests or consultants' opinions. He may hesitate, too, to refer a patient for consultation or other special service because of the cost to the patient.

GROUP CAN CONTROL FEES

This situation may also obtain in group practice, of course, but to a lesser extent because, in the first place, the group can control the fees for all the services the patient needs and can temper the wind when necessary, while the individual practitioner usually cannot greatly influence the fees set by the individual consultants to whom he refers patients. Second, it is the practice in many medical groups—and a good practice it is, too, for improving quality—to make no charge for consultations; specialists' fees are charged only when the patient has been transferred to the specialist for continuing study or treatment.

Probably the strongest motive against utilizing referral services to full effectiveness in individual practice is the competitive element. In its crudest form, this means that a physician may not refer his patient to another physician for fear that he may "lose" his patient (and his fee) permanently to

a completely **new** approach to cough relief



The antispasmodic and decongestant action of **BENYLIN EXPECTORANT** combats cough, relaxes the bronchial tree, diminishes bronchial congestion and alleviates nasal stuffiness, sneezing and lacrimation. Containing no narcotics, **BENYLIN EXPECTORANT** combines Benadryl® hydrochloride, 10 mg. per teaspoonful, with other remedial agents for safe, effective control of coughs due to colds as well as those of allergic origin.

BENYLIN[®] **EXPECTORANT**

promotes liquefaction and removal of mucous secretions from the respiratory tract. The demulcent action of its vehicle soothes irritated mucosa. Acceptable alike to children and adults, its pleasant, mildly tart taste avoids the objections to cloying, overly-sweet preparations.

DOSAGE: One or two teaspoonfuls every two to three hours, as soon as possible following appearance of symptoms. Children, $\frac{1}{2}$ to one teaspoonful every three hours.

BENYLIN EXPECTORANT contains in each fluid ounce:

Benadryl Hydrochloride	80 mg.
(diphenhydramine hydrochloride, P. D. & Co.)	
Ammonium Chloride	12 gr.
Sodium Citrate	5 gr.
Chloroform	2 gr.
Menthol	1/10 gr.

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the second doctor. More subtly, it means that a physician may fear that by calling for frequent consultations he will undermine the patient's confidence in his own ability. He may believe that his reputation for self-reliance, broad medical knowledge, and skill will suffer among his colleagues if he calls on others too much. Most of all, perhaps, he may fear that the consultant will find errors in his work and "show him up" to both the patient and the profession.

For all these reasons and for at least one more, namely, the sheer physical inconvenience to the patient of going about from one office to another, making numerous appointments with varying periods of delay before seeing the different doctors, and so on, there is an inevitable tendency in individual practice not to employ the whole medical team to the extent it should be used for realizing the full potential of modern medical service of high quality.

The physician in solo practice, therefore, is often obliged to try to perform a range of service up to and sometimes beyond the limits of his technical capacity. This, of course, adversely affects the quality of service obtained by the patient and in the long run tends to produce in the physician a habit of superficial performance, trusting in luck and nature that his lack of thoroughness and specialized knowledge will not cause errors resulting in serious disablement or death.

FEE-SPLITTING REARS ITS HEAD

On the other hand, somewhat paradoxically, the physician in individual practice may under some circumstances refer his patients too frequently to other physicians. Here the practice of fee-splitting rears its ugly head. Fee-splitting, like the other evils mentioned, does not occur because of any desire of physicians to perpetuate a harmful practice but arises almost inevitably out of the character of the individual practice system. I dare say it will continue, in spite of all the laws and professional pronouncements that can be devised, as long as this system is the prevalent method of practice.

Here, again, the basic reason is the advances in medical science which make specialization a necessity. One can hardly expect the general physician who has correctly diagnosed a case of appendicitis on a \$10 house call not to feel that he deserves a lot of the credit for saving the patient's life and not to gaze at the surgeon's \$200 or \$300 fee

with some envy. Moreover, one can understand that the specialist (particularly the young one, just starting in practice) in a fiercely competitive situation may yearn to reward tangibly the general physicians who most assist him in building up his practice by referring cases to him.

It is not the act of splitting a fee, however, that makes this practice an evil and an impediment to a high quality of medical care. It is, rather, the fact that the split is unknown to the patient and unregulated in amount and volume. Thus, the patient does not know when he buys a pair of eyeglasses from an optician, for example, that part of what he pays may go back to the doctor who referred him to that optician. The same goes, of course, for x-ray examinations, surgical procedures, and so on.

The result of hidden fee-splitting naturally is that if a sizable split is in the offing the physician may be tempted to refer patients more frequently than is medically necessary and, equally bad, to send his cases to the doctor or laboratory or optician who gives the biggest kickback rather than the one professionally most competent to handle the case. The magnitude of the practice of fee-splitting may perhaps be gauged by the fact that more than 4000 eye specialists—about one-half of those in the United States—were involved when the U.S. Department of Justice sought to stamp out rebates in the optical industry.

The utter futility, under our individual practice system, of expecting the medical profession to cope with this evil is illustrated by what occurred in New York City in the fee-splitting scandals under workmen's compensation a few years ago. Almost 2800 physicians were charged with participation in the fee-splitting racket; 117 were definitely exonerated. More than 1000 were definitely found to have been implicated. A few lost their licenses to practice medicine. But a diligent, personal search of the published records of all medical societies in New York fails to disclose a single instance in which any of the remaining 900 "definitely implicated" physicians was suspended or expelled by a medical society. This is a commentary not only upon the durability of fee-splitting in the individual practice system, but also upon the ability of medical societies to set and maintain professional standards in general. It is in interesting contrast with the

promptness and vigor displayed by medical societies in disciplining members who participate in group practice associated with prepayment plans for comprehensive medical care.

Group practice is sometimes considered to be a type of fee-splitting. This is true in the sense that a patient's payment is divided according to the group's internal administrative provisions and does not go exclusively to the doctor or doctors who treated that particular patient. But group practice most emphatically is *not* fee-splitting in the sense that this open division of income among the physicians of a group is never a kickback paid for favors received.

PATIENT KNOWS THE SCORE

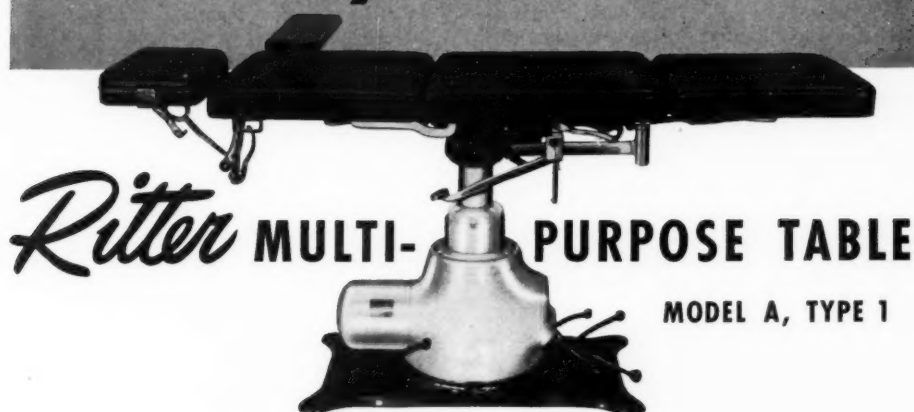
The patient knows all along that he is paying the group for his service, not an individual physician, and he fully expects the group to divide its income equitably among its members. So division of income by the group method completely eliminates the evils of the hidden kickback system and yet, at the same time, provides a distribution of income among general physicians and specialists more equitable than is possible in solo practice unless fees are split.

Earlier in this paper it was said that group practice was *almost* automatically conducive to a high quality of care. Now for the "almost." For one thing, physicians in group practice are still human beings and, like the rest of us, they do not always get along harmoniously, on either professional or economic grounds. The very closeness of their day-to-day relationship tends to emphasize any differences among the doctors in a group much more strongly than would be the case among the same men in twenty or thirty individual offices scattered all over town. This means, of course, that good methods of self-government, of administration, and of settling disputes are essential for the successful operation of any medical group.

Then, too, group practice can and sometimes does develop an impersonal attitude toward patients which may result in physicians dealing with people as case numbers or case "material" rather than as living persons with emotions, home difficulties, and business problems, living in a community. This is by no means inherent in the group method but must be guarded against or corrected if it appears.

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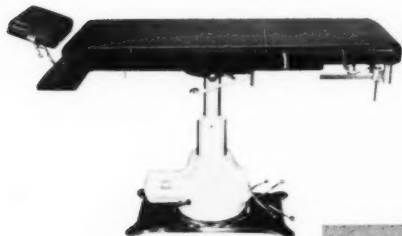
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against such an impersonal attitude used by many groups is to make sure that each patient of the group has one—usually a general—physician whom he regards as his family doctor and who, in his turn, assumes real responsibility for the welfare of that particular patient at all times, or at least until the patient (or the doctor) decides he should be under the care of another physician.

Limitation on choice of physician sometimes makes both patients and physicians distrust group practice. It is sometimes claimed, indeed, that the

competitive element in free-choice individual practice is a stimulus toward improved quality in the service rendered by the competing physicians. This seems at best a dubious contention, for the untrained "customer" is exceedingly poorly equipped to judge the quality of a physician's service and may likely be influenced mostly by factors having little to do with quality. For shoes or iceboxes or even politicians the public may have some basis to make a judgment, but how can it evaluate a surgeon's skill or a bacteriologist's competence?

On the other hand, the kind of competition found in individual practice places an emphasis on quantity of service and upon the money received for it that certainly distracts the doctor's attention from its qualitative aspects, to put it mildly. Healthy competition exists within medical groups, as has already been pointed out. Vigorous competition often exists between two or more medical groups also. So group practice can make use of the good features of competition, which are conducive to high quality, while avoiding most of the bad features, which do it harm.

To return to choice of physician, choice naturally is limited within any one group, although patients may, of course, leave the group entirely if they wish, and the choice is in any case much less limited than is that of the patient in the ward or outpatient department of a voluntary or public hospital. Most groups encourage their patients to select freely among the physicians who are competent in the particular field of service they require. Groups also permit patients to change physicians if they wish. On the positive side, a group is in an excellent position to guide a patient intelligently in the choice of the physician best suited to his needs. Such guidance seems usually to be gratefully accepted by the patient, if it is given tactfully and thoughtfully.

Some groups have irritated their patients by a confusing welter of administrative detail, numerous records to be made out, involved appointment systems to be dealt with, complicated procedures to be followed, puzzling mazes of corridors, examining rooms, laboratories to be solved, and so on. These are real danger points, especially in a large group, but most of them can usually be avoided by the exercise of a little skillful and patient administrative effort.

Another frequent charge is that, in group practice, physicians are likely to use the readily accessible consulting, laboratory and x-ray services too freely—in other words, to show a tendency to give every patient "the works," whether he needs it or not, often at extravagant expense. This obviously can happen. But studies of numerous groups in actual operation indicate that it happens infrequently and need not happen at all. Indeed, an interesting study made two years ago by the Pennsylvania Hospital Association showed that in several sample private groups



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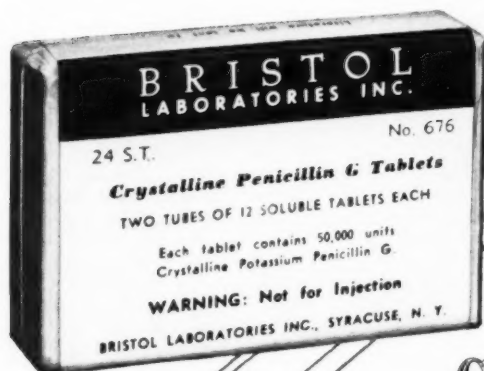
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patients' total fees for accessory services were considerably less than they would have been for the same services procured through solo practitioners and in several instances less than the fees would have been in voluntary hospital outpatient departments. As a matter of fact, a well administered group can control excessive use of such services far better than can individual practitioners.

Finally, it is sometimes said that physicians in medical groups tend to stick too close to their building, being reluctant to make home visits or go to rural areas. This also can happen and has happened, particularly in the so-called "reference" groups. Again, however, this weakness is not inherent in the group method. Many groups diligently serve the people of their communities at home or wherever else they need to be cared for, and some have

successfully established part-time or full-time outposts in small towns or rural areas which were so small or so poor that they had for years been unable to support an individual practitioner. But because the outpost doctor also could spend part of his time in the group's center and could send patients there for complicated problems, the group could easily afford to serve the little community without mileage fees or hurried, long ambulance trips.

It can be seen, therefore, that there are indeed many problems to be solved and many dangers to be avoided if group medical practice is to provide the high quality of medical care it is potentially capable of rendering. Still, none of these appears to be so intimately a part of the group method that it cannot be successfully attacked if patience, intelligence and energy are devoted to it.

sodium salt of Gantrosan by daily oral administration for a period of ten days. The animals were then sacrificed and no crystalline deposits or pathological changes were found in the kidneys. If, however, other sulfonamides were given to rabbits under comparable experimental conditions even smaller doses of these drugs produced crystallization in the kidney with all the characteristic symptoms of oliguria and acid reaction.

Blood levels. The Bratton-Marshall method can be used for the determination of Gantrosan. The blood levels of Gantrosan seem to be of about the same order as those previously reported for other N¹-substituted sulfonamides. The intravenous administration of 9.050 g. kg. in mice gave a blood concentration of 8 mg. per cent after half an hour which fell to 2.2 mg. per cent after three and one-half hours. The rats on the 2 per cent Gantrosan diet showed blood levels of 12 to 18 mg. per cent. The rabbits that received 0.794 g. kg. of the sodium salt per os daily gave levels of 10 to 20 mg. per cent on the eighth day. Forty-three to sixty-one per cent of the orally administered drug was eliminated through the kidneys and the larger part of it (68 per cent) in the unacetylated form. The ratio of the free to acetylated compound was 2:1.

E. K. Marshall Jr. studied the distribution of Gantrosan in the body and found that it differed from that of the other sulfonamides. Sulfanilamide and sulfapyridine are localized to a slight degree in tissue. Sulfathiazole, sulfadiazine, sulfapyrazine and sulfamerazine penetrate tissues to a lesser extent since they are distributed in a volume corresponding to 45 to 55 per cent of the body weight. Gantrosan, on the other hand, is distributed in a volume corresponding to only 25 to 30 per cent of the body weight.

This observation that Gantrosan is apparently distributed only in the extracellular fluid has two important clinical implications. First, the same amount of Gantrosan should give blood levels about twice that of sulfadiazine or sulfamerazine, and three times the concentration of sulfanilamide. Second, the apparent failure of this new drug to penetrate cells should make it less toxic than those sulfonamides which enter the tissues.

Antibacterial spectrum. In general the antibacterial spectrum of this new sulfonamide is similar to that of sulfa-

Notes and Abstracts

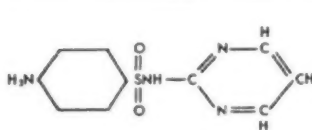
Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

GANTROSAN

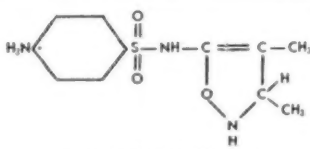
A NEW sulfonamide of considerable promise is 3,4-dimethyl-5-sulfanilamido-isoxazole. This compound has been reported in the medical literature by its experimental designation "Nu-445." It will shortly be available under the proposed trade name "Gantrosan."

examination of various tissues and organs.

The last group was kept on the diet for 182 days and received a total dosage of Gantrosan as high as 245 g. kg. (average daily intake 1.35 g. kg.). There were no significant changes in the blood picture. No path-



SULFADIAZINE



GANTROSAN Nu-445

PHARMACOLOGY

Toxicity. As with other sulfonamides, the acute toxicity is low, the oral LD₅₀ for the rat and mouse being 10 g./kg. (calculated as the free sulfonamide). Schnitzer, Foster and their co-workers studied the chronic toxicity of Gantrosan by feeding twenty-four young rats a diet containing 2 per cent Gantrosan. The animals were sacrificed at different intervals for histological

ological changes attributable to the drug were found and it is highly significant that no kidney calculi and no inhibition of normal growth occurred in these animals.

Gantrosan has a remarkably good solubility over a wide pH range. The practical importance of this high solubility was demonstrated by the following experiment. A group of six rabbits received 0.794 g. kg. of the

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1. Gordon, E. J. (Surgery, 7:686, 1940)

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diazine. The bacteriostatic activity *in vitro* showed it to be moderately effective against most gram-positive organisms but with a definite bacteriostatic effect against certain gram-negative bacteria. *In vivo* animal experiments demonstrated the efficacy of Gantrosan against three types of Group A strain streptococci hemolyticus; type I, II and III pneumococci; staphylococci; C. diphtheriae; meningococci; S. schottmuelleri; Klebsiella A and E. coli. The *in vitro* bacteriostasis against E. coli could be almost completely inhibited by p-aminobenzoic acid.

CLINICAL REPORTS

Urinary tract infections. As might be expected, Gantrosan is of particular interest to urologists because of its antibacterial spectrum and high solubility. Among those who have published reports on the use of Gantrosan in urinary tract infections are Sarnoff, Freedman and Hyman; Lazarus and Schwartz; Rhoads, Svec and Rohr; Haines and Miceli; Narins, and Rodgers and Colby. Sarnoff reported on fourteen cases of Bacillus proteus infections of the urinary tract. Gantrosan apparently favorably influenced

eleven cases and in nine produced bacteriological reversals, consisting of three successive negative cultures. A review of the literature indicates that Gantrosan will produce a bacteriological reversal in a considerable proportion of infections due to Bacillus proteus and Bacillus coli. The results in treating Bacillus pyocyaneus (Pseudomonas aeruginosa) infections have not been consistent.

Meningococcus meningitis. Rhoads and his associates treated seven cases with Gantrosan as the sole bacteriostatic agent and had no failures.

Miscellaneous. Gantrosan has also been reported to be effective in the treatment of respiratory tract infections, erysipelas, scarlet fever, cellulitis, otitis media and tonsillitis. Rhoads and Schram compared the effectiveness of penicillin and Gantrosan in preventing bacteremia following tooth extraction. A control group which received no preoperative medication showed positive blood cultures for nonhemolytic streptococci in 35.3 per cent.

Twenty-eight patients received 300,000 units procaine penicillin in oil I.M. two hours before extraction; of these, two had positive blood cultures. Eight cases received 100,000 units of penicillin in aqueous solution two hours preoperatively and there were no positive cultures. Eighteen patients received two grams of Gantrosan orally two hours before extraction and none of these developed positive blood cultures.

Blood levels in man. Rodgers and Colby failed to find any relation between the blood or urine sulfonamide levels and the bacteriostatic properties of the drug in their series of urinary tract infections. Narins, on the other hand, was able demonstrably to increase the effectiveness of Gantrosan against Bacillus proteus and Bacillus coli urinary tract infections by raising the dose from 6 grams to 8 grams per day.

Sarnoff gave three patients an initial oral dose of 3 grams followed by 2 grams every eight hours and reported that the average free and total blood levels were 16.0 and 19.3 mg. per cent respectively after one day's treatment. The daily administration of 6 grams Gantrosan gave the following blood levels, according to Rhoads: Oral—5.85 mg. per cent free, 9.17 mg. per cent total. Intramuscular—6.67 mg. per cent free, 9.29 mg. per cent total. Intravenous—11.7 mg. per cent free,

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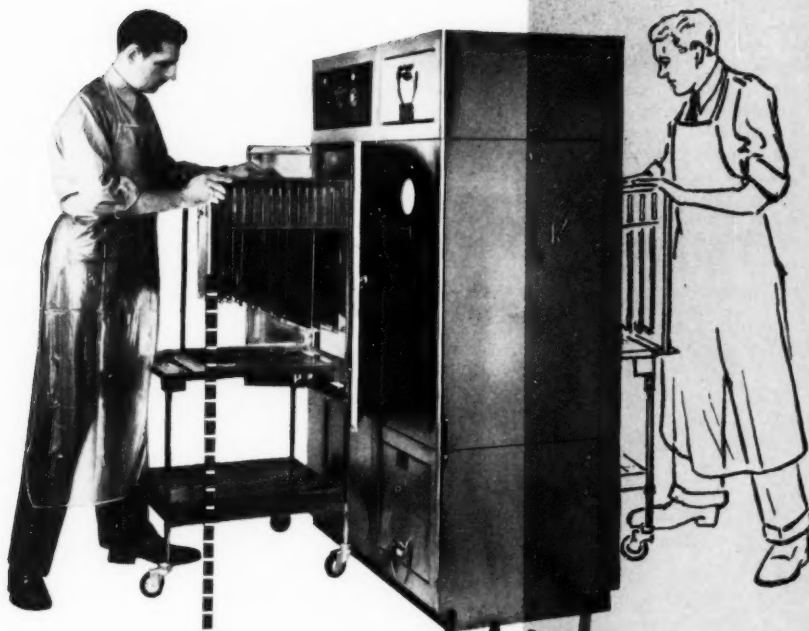
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16.7 mg. per cent total. His report of 28 to 35 per cent acetylation in the blood confirms in man the data obtained from animals by Schnitzer.

Toxic reactions. The reports now available indicate that the toxicity of Gantrosan will probably be low. The literature reports 237 of 254 cases treated with Gantrosan with no serious side effects. Narins treated fifty patients with 6 to 8 grams of Gantrosan per day for 6-60 days and reported two cases each of dermatitis and nausea. He found no evidence of leukopenia, nor was there any indication

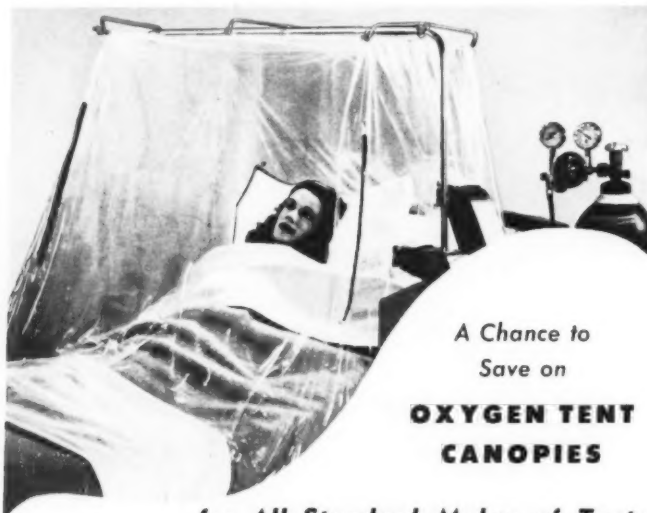
of deposition of crystals within the urinary tract, although no concomitant alkali medication was given and fluid intake was not forced.

In a series of 106 cases, Rhoads reported: "The reactions were somewhat similar to those encountered with other sulfa drugs although they occurred less frequently (nine instances in the series of 106 cases). Crystalluria was especially infrequent, occurring in two patients on a single occasion. These promptly disappeared without stopping the drug. A generalized rash occurred in one patient who also

had this type of reaction to sulfadiazine and sulfathiazole. Nausea and vomiting appeared in five instances, hematuria in one, and headaches in two."

The following case reported by Sarnoff is of special interest regarding the safety of Gantrosan. In a trial involving one individual, the intravenous injection of 18 grams over a period of four hours was tolerated without symptoms. The same patient (also on oral therapy) later received a single intravenous dose of 12 grams, injected within ten minutes. Pallor and sweating were noted for a few hours. Crystalluria, microscopic hematuria, and a transient rise in the blood urea nitrogen occurred in the ensuing three days. In this connection, it might be commented that usual clinical requirements would seldom, if ever, dictate the administration of even a fraction of the dose given this subject.

Gantrosan has been used extensively in adult patients without producing crystallization in the kidneys even though no adjuvant alkali therapy or forced fluids were administered. Also in children these protective measures proved to be not required; children tolerated the treatment, with Gantrosan well and kidney disturbances have not been reported.



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DOSAGE SCHEDULE

Oral treatment. In the treatment of systemic infections, it is suggested the dosage schedule follow that usually recommended for sulfadiazine, although the facts relating to optimal intake of the drug have yet to be established. Accordingly, adults suffering from pneumococcal pneumonia, severe hemolytic streptococcus infections, severe staphylococcus infections or meningococcal meningitis should receive an initial dose of 4 to 6 grams (depending upon body weight).

In pneumococcal pneumonia, this should be followed by a dose of 1.0 to 2.0 gm. every four hours day and night until the temperature has been normal for seventy-two hours. In severe streptococcal, staphylococcal and meningococcal infections, subsequent treatment should provide 1.0 to 2.0 gm. every four hours day and night until the temperature has been normal for from five to seven days. In milder infections, dosage should be correspondingly less. In any event, dosage should be controlled whenever possible by repeated blood level determinations. It is believed a blood level



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1. Carrier, Krug, Lott & Glenn: Journal-Lancet, June, 1948.

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of 10-12 mg. per cent will be satisfactory in the average case. In urinary infections, the dosage commonly employed ranges from 8 to 10 grams daily in divided doses. Occasionally patients have received 12 grams or more daily without apparent harm.

Parenteral treatment. Intravenous or intramuscular injection of 1.0 gm. or more every four hours.

How supplied. Gantrosan is available in oral tablets of 0.5 gm. There are also experimental solutions for parenteral use of 10, 20 and 40 per cent concentrations of Gantrosan. The

Gantrosan solutions have also been successfully employed as diluents for penicillin where joint penicillin-sulfonamide therapy was desired.

Precautions. The usual precautions required in sulfonamide therapy should be observed during treatment with Gantrosan. Signs of intoxication, such as urticaria, drug rash, nausea and vomiting, sulf- or methemoglobinemia, toxic hepatitis or jaundice, leukopenia and central nervous system disturbances, should prompt the immediate discontinuance of the drug.—M. J. SCHIFFRIN.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

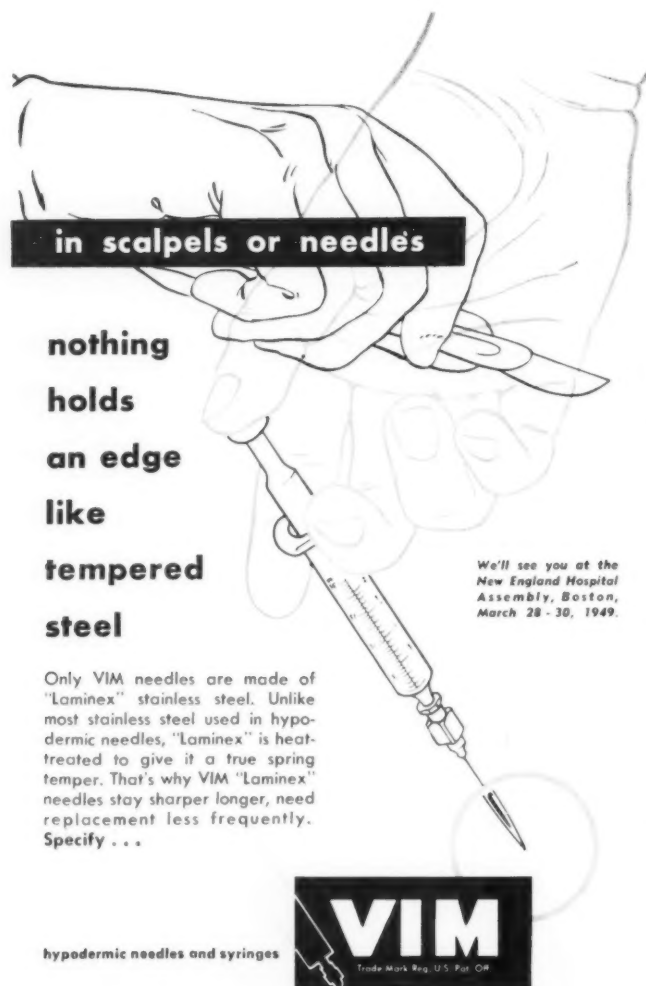
The Nature of Stuttering

In the opinion of Philip J. Glasner, in an article entitled "Nature and Treatment of Stuttering," appearing in the *American Journal of Diseases of Children*, August 1947, many physicians treat stuttering as a temporary phenomenon, usually outgrown, and to be ignored. Unfortunately, these physicians do not follow the child to adulthood and hence do not know that many surveys have revealed the same incidence of stuttering at the college level as in the third grade.

In the last twenty years, laboratory and clinical findings have revealed that the causes of stuttering are psychogenic rather than physical. Stuttering symptoms vary widely; causative factors are multiple, and any condition or situation which can produce disturbances of a behavioral or emotional nature may precipitate the kind of speech called stuttering. Relaxed, effortless repetitions, in young children especially, are not to be regarded as stuttering, but as the normal hesitations of speech development. When the speech is characterized by changes in muscle tonus, pitch, speed and rhythm, and by longer hesitations, strained and obvious repetitions, then only may it be considered true stuttering.

When the stuttering causes can be determined, and removed early in childhood, the disorder soon disappears without recurrence. If the causes are not removed, stuttering becomes progressively worse and when, sooner or later, parents or society places the stigma of "stuttering" upon his speech, the child becomes apprehensive in speech situations and develops a fear of stuttering. Emotional and personality changes follow.

Treatment should be undertaken following a complete and careful examination. The young child should never be made to feel abnormal, and symptomatic treatment should be casual and simple. The older child, adolescent or adult, with firmly established stuttering and personality patterns must be oriented to his problem and become objective about his speech.—LAURA S. ROSENFELD.



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an edge
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tempered
steel**

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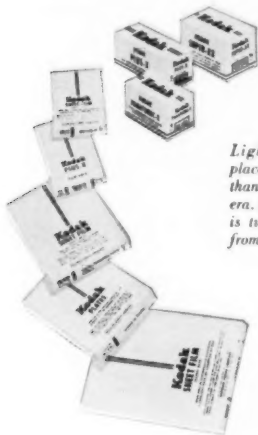
Picture the patient's progress

...with photograph...after photograph

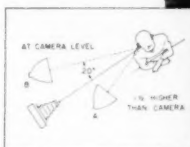
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MANY MAIN DISHES FEATURE GROUND MEATS

REBA STAGGS

Director, Department of Home Economics
National Live Stock and Meat Board, Chicago

GROUND meats offer almost unlimited variety on the menu. Flavors to the liking of every individual come from carefully combining beef, veal, pork or lamb or a combination of these meats and the right amounts of appropriate seasonings. To the meat and seasonings, add other desired ingredients, which usually include a filler, a binder and enough liquid to keep the proper balance so the finished dish will be moist. The meat mixture may be cooked as patties, muffins, loaves, meat balls, each with its own particular appeal as the center of the menu.

Choose—Beef, Veal, Pork, Lamb

Many cuts of beef, veal, pork and lamb may be used in ground meat dishes. Usually the less tender cuts and the less demanded cuts are chosen for grinding. Grinding makes the less tender meat tender enough for cooking by the same methods as are used for the tenderer cuts. Using less demanded cuts is an economical way of providing

the good flavor and high nutritive value of meat.

Beef chuck, plate and flank; veal shoulder, breast, neck and shank; pork picnic shoulder or Boston butt; lamb shoulder, shank and breast, and trimmings from these cuts are all excellent for grinding. Some of the variety meats, particularly liver, heart and kidney, are also ground for many flavorful and highly nutritious main dishes.

In addition to the recipes which feature a single kind of meat, many favorites are built around combinations of meat flavors. Good ones are beef and fresh pork; beef and veal; veal and fresh pork; veal and smoked pork; veal and fresh pork sausage; fresh and smoked pork, and lamb and veal. Ground ready-to-serve meats and ground leftover cooked beef, veal, pork

(Continued on Page 114.)

Right: Sausage patties with lima beans and carrots. Below: Sausage-apple patties served with buckwheat cakes.



BAKED SAUSAGE PATTIES

Number Servings: 50		Size Serving: 3 oz. meat		Total Yield: 50 3-oz. balls 100 1½-oz. balls	
Ingredients	Amount	Ingredients	Amount		
Pork sausage	10 lb.	Grated apple	5 c.		
Bread	10 slices	Salt	3 tbsps.		
Eggs	1 pt. (8 to 10)				

1. Break bread into small pieces.
2. Combine sausage, bread and remaining ingredients. Mix well.
3. Shape mixture into 50 3-oz. or 100 1½-oz. balls and place on a rack in an open roasting pan.
4. Bake in a moderate oven (350°F.) for approximately 45 minutes.



*D*iscernment

Winning kudos from connoisseurs is an established habit of Sherman Blend tea. Its exquisite bouquet—iced or hot—is discerned at first sip by the discriminating patron. Such instant and enduring popularity makes it the most economical tea you can serve. At a fraction of a cent more per cup you win lasting guest satisfaction.

JOHN SEXTON & CO., 1949



Good Food for Pleased Guests

Sexton
Quality Foods

MEAT BALLS AND SPAGHETTI

Number Servings: 50	Size Serving:	Total Yield: 100 meat balls
	2 meat balls	
	3 oz. meat	
	approx. $\frac{3}{4}$ c. spaghetti	

Ingredients	Amount	Ingredients	Amount
Spaghetti	3 lb.	Dry bread crumbs	1 pt.
Canned tomatoes	2 No. 10 cans	Eggs	1 pt. (8 to 10)
Salt	3 tbsp.	Finely chopped celery	1 c.
Pepper	1 tsp.	Salt	2 tbsp.
Onion, chopped fine	$1\frac{1}{2}$ c.	Milk	3 c.
Lard or drippings	$\frac{3}{4}$ c.	Flour	2 c.
Ground meat	8 lb.		

1. Cook spaghetti in steamer or in boiling salted water.
2. Heat tomatoes to boiling point. Add cooked unbroken spaghetti, salt and pepper.
3. Brown onions in fat and add to tomatoes.
4. Beat eggs slightly. Combine eggs, meat and remaining ingredients. Mix well.
5. Make into $1\frac{1}{2}$ -ounce balls. Roll balls in flour and fry in deep fat until brown, about 5 minutes.
6. Arrange meat balls, spaghetti and sauce in baking pan.
7. Bake in slow oven (300 F.) 45 minutes to 1 hour.

POTATO-BEEF-BURGERS

	Size Serving:	Total Yield:
Number Servings: 50	1 large patty	50 patties

Ingredients	Amount	Ingredients	Amount
Ground beef	6 lb.	Salt	3 tbsp.
Unpeeled potato, coarsely grated	3 qt.	Pepper	$1\frac{1}{2}$ tsp.
Grated onion	$1\frac{1}{2}$ c.		

1. Combine ingredients. Mix well. Shape into patties.
2. Place patties in frying pan to which a small amount of lard or drippings has been added, or place on a well greased griddle.
3. Brown patties on both sides, turning frequently to ensure even cooking.
4. Cook until done, about 8 to 10 minutes.

BEEF CUPS WITH CREAMED POTATOES

Number Servings: 50	Size Serving:	Total Yield
	1 medium muffin	50 cups

Ingredients	Amount	Ingredients	Amount
Ground beef	6 lb.	Creamed Potatoes	
Bread crumbs	2 c.	Potatoes	8 lb.
Milk	$1\frac{1}{2}$ pt.	Milk	$\frac{1}{2}$ gal.
Salt	2 tbsp.	Salt and pepper	To season
Pepper	$\frac{1}{2}$ tsp.		

1. Make creamed potatoes as follows: Peel and dice potatoes. Place potatoes in pan with 2 quarts milk. Cover and cook slowly for about 20 minutes. Remove cover and cook until thick. Add seasonings.
2. Combine ground beef and remaining ingredients.
3. Line medium-sized muffin pans with the meat mixture to a thickness of $\frac{1}{4}$ inch.
4. Fill meat muffins with creamed potatoes and bake in a moderate oven (350 F.) for 30 minutes.

HOT PORK LOAF

Number Servings: 50	Size Serving:	Total Yield:
	3 to 4 oz.	six loaves (2½ lb. ea.)

Ingredients	Amount	Ingredients	Amount
Ground pork	8 lb.	Onion, finely grated	$\frac{1}{2}$ c.
Cracker crumbs	3 qt.	Salt	2 tbsp.
Milk	3 qt.	Paprika	$1\frac{1}{2}$ tsp.

1. Combine meat and remaining ingredients. Mix well.
2. Pack into 6 greased 5x9-inch loaf pans.
3. Roast in a moderate oven (350 F.) for $1\frac{1}{2}$ hours.



Casserole of meat balls and spaghetti; vegetable salad.

HAM TIMBALES

Number Servings: 50	Size Serving:	Total Yield:
	4 oz.	1 1/2 gal.

Ingredients	Amount	Ingredients	Amount
Cooked ham, ground	6 lb.	Grated onions	1 c.
Eggs, slightly beaten	6	Pepper	$\frac{1}{4}$ tsp.
Flaked bread crumbs	$1\frac{1}{2}$ qt.	Milk or meat stock	4 to 6 c.

1. Combine meat, eggs and remaining ingredients. Mix well.
2. Pack mixture into greased custard cups, using 4 ounces to a serving.
3. Place in pan of water and cook in a slow oven (325 F.) about $1\frac{1}{2}$ hours or until set.
4. Turn out onto warm plates and serve hot with tomato sauce or a fruit sauce.

HAM AND SWEET POTATO PUFF

Number Servings: 50	Size Serving: $\frac{3}{4}$ c.	Total Yield: 2 gal.
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Ingredients	Amount	Ingredients	Amount
Chopped cooked ham	$\frac{1}{2}$ gal.	Pepper	1 tsp.
Eggs	16	Milk	3 qt.
Margarine or drippings	1 c.	Toasted bread crumbs	1 qt.
Mashed sweet potatoes	$\frac{1}{2}$ gal.	Brown sugar	1 c.

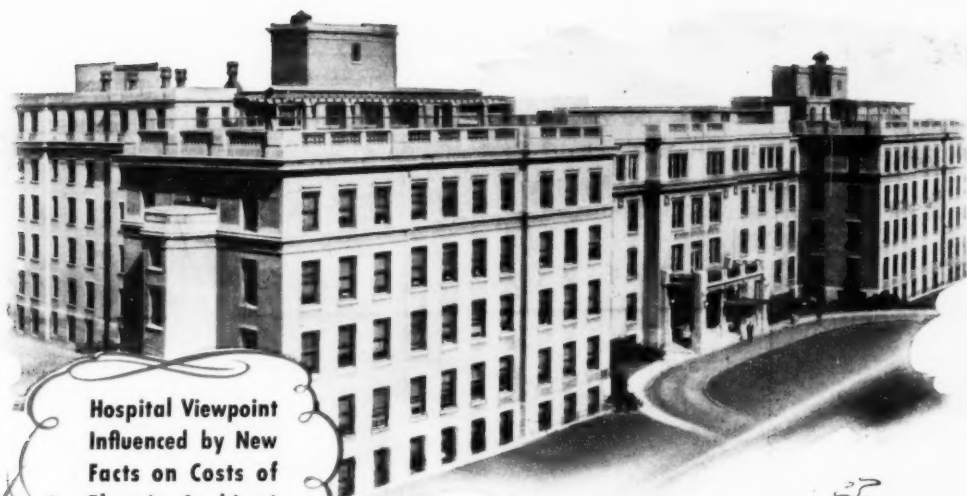
1. Combine ham, 10 eggs, margarine or drippings, sweet potatoes, pepper and 2 quarts milk.
2. Place mixture in greased baking dish.
3. Beat remaining eggs, add remaining milk and toasted bread crumbs.
4. Spread over ham mixture.
5. Sprinkle with brown sugar and bake in a moderate oven (350 F.) for 30 minutes.

INDIVIDUAL HAM AND MACARONI LOAVES

Number Servings: 50	Size Serving:	Total Yield:
	3 oz.	50 loaves

Ingredients	Amount	Ingredients	Amount
Ground smoked ham	4 lb.	Macaroni, cooked and chopped	$\frac{1}{2}$ gal.
Ground lean pork	2 lb.	Cheese sauce (medium thick)	$\frac{1}{2}$ gal.
Eggs	4		

1. Combine all ingredients thoroughly.
2. Pack into greased muffin pans.
3. Bake in moderate oven (350 F.) for 1 hour.



Hospital Viewpoint
Influenced by New
Facts on Costs of
Electric Cooking!

ANOTHER STORY OF EXTRAORDINARY SAVINGS WITH **HOTPOINT ELECTRIC COOKING**—

from the Methodist-Episcopal Hospital, Indianapolis with 1,045 on the payroll, 645 beds, and 85 bassinets.

Here's fresh new evidence of the rapidly mounting trend to electricity in commercial cooking—more dramatic proof of the low cost of Hotpoint Electric Cooking. Methodist-Episcopal, one of America's outstanding progressive hospitals, installed Special Meters to measure electric cooking costs—to get them scientifically accurate—right down to a fraction of a penny. After months of careful checking, here is **METERED-PROOF** of the low cost of Hotpoint Electric Cooking at Methodist-Episcopal:

152 Watts, Per Meal, Per Person

(at a 2c rate, 152 watts would cost less than $\frac{1}{3}$ of a penny, per meal, per person.)

But this saving is only part of the story. Methodist-Episcopal discovered that the even distribution of

controlled heat with Hotpoint Electric Cooking cut food costs up to 20%. With the old-fashioned flame-type equipment, 5% of all meat was so badly seared it couldn't be used. Meat shrinkage and fat consumption were much greater. These losses changed to important savings with Hotpoint Electric Cooking.

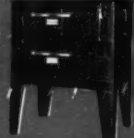
Next, came cuts in labor and maintenance costs. Scouring and scrubbing, a constant high cost with flame-fuel cooking, was reduced to a minimum with **CLEAN** Hotpoint Electric Cooking—there are no products of combustion to accumulate on walls, ceilings, and utensils with Hotpoint Electric Cooking.

In addition to these money-saving advantages, the positive temperature controls of Hotpoint Electric Cooking permit a great variety of healthful, nourishing, appetizing foods—more appealing, more digestible foods with most of their nutritious juices and natural flavors retained.

Perhaps you, too, have felt the influence of facts like these pointing to the many advantages of Hotpoint Electric Cooking. Perhaps these advantages will end your search for greater economy and improved quality standards of the food you serve. Let the Hotpoint man bring you the complete story of Hotpoint Electric Cooking. Simply mail the handy coupon provided.



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Hotpoint 3-Burn Electric Oven with double broil evenly distributed throughout broiling compartment.

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Porcupines, succotash, mixed vegetable salad.

LAMB AND BACON WHIRLS

Number Servings: 50		Size Serving: 1-inch slice	Total Yield: six rolls 8 to 10 inches long
Ingredients	Amount	Ingredients	Amount
Sliced bacon	3 lb.	Marjoram	1/2 tbsp.
Ground lamb	9 lb.	Worcestershire sauce	6 tbsp.
Salt	2 tbsp.	Corn flakes	1 1/2 qt.
Pepper	1/2 tsp.	Meat stock, water or tomato juice	1 c.

1. Arrange slices of bacon, by slightly overlapping, on 6 sheets of wax paper, about 8 by 10 inches.
2. Mix ground lamb and other ingredients.
3. Spread and pat lamb mixture evenly over the bacon.
4. Roll, like jelly rolls, lengthwise of the bacon slices.
5. Wrap tightly in wax paper and chill thoroughly.
6. Before slicing, place wooden picks through the roll at 1-inch intervals to hold the bacon in place.
7. Slice 1 inch thick. Broil, griddle broil or pan fry to the desired degree of doneness.

SCOTCH PANCAKES

Number Servings: 50		Size Serving: 2 medium	Total Yield: 100 pancakes
Ingredients	Amount	Ingredients	Amount
Cooked rolled oats	1 gal.	Pepper	To season
Ground cooked lamb	1 gal.	Meat drippings	1 c.
Eggs, slightly beaten	16	OR	
Salt	To season	Lard	1/2 lb.

1. Mix thoroughly cooked oats, meat, eggs and seasonings.
2. Fry cakes, in small amount of fat, using rounded tablespoon of mixture for each cake.

or lamb form the basis for many delicious recipes. Sometimes they are used in combinations, or they may often, with a bit of seasoning adjustment, be used interchangeably in recipes.

Use—Variety of Seasonings

There are seasonings to please every palate. Some individuals prefer only salt, pepper and maybe onion, while others like the distinctive flavor of additional spices and herbs. Proportions

vary depending upon the strength of the particular seasoning as well as personal preference. In any case, it is better to use too little than too much. Amounts of salt, pepper and onion are more or less standard; a good rule to follow is: for each pound of ground unsalted meat, use 1 teaspoon salt, 1/4 teaspoon pepper, and 1/4 cup grated onion. The amount of salt would obviously need to be reduced if part of the ground mixture

PORCUPINES

Number Servings: 50		Size Serving: two 2-oz. balls	Total Yield: 100 balls
Ingredients	Amount	Ingredients	Amount
Ground beef	10 lb.	Paprika	1/4 c.
Bread crumbs	1 qt.	Uncooked rice	5 c.
Chopped onion	1 1/2 pt.	Tomato soup	2 1/2 qt.
Chopped green pepper	1 1/2 c.	Boiling water	3 qt.
Salt	1/4 c.		

1. Combine ground beef, crumbs, onion, green pepper, salt and paprika. Mix well.
2. Shape into 100 2-oz. balls. Roll each ball in rice and press the rice into the meat so that as it cooks it will cling to the ball of meat.
3. Place meat balls in pan, cover with tomato soup and boiling water. Cover and simmer about 45 minutes.

INDIVIDUAL LIVER LOAVES WITH BACON

Number Servings: 50		Size Serving: 4 oz.	Total Yield: 50 loaves
Ingredients	Amount	Ingredients	Amount
Sliced liver	12 lb.	Pepper	1 tsp.
Lard or drippings	4 tbsp.	Marjoram	2 tsp.
Bacon	1/2 lb.	Cracker crumbs	1/2 gal.
Onions	2 lb.	Liquid (tomato juice, milk or bouillon)	3 qt.
Eggs, slightly beaten	16	Catchup	1 qt.
Salt	3 tbsp.	Bacon	2 lb.

1. Cook liver slowly 5 minutes in frying pan to which lard or drippings has been added.
2. Put liver through food chopper with 1/2 pound bacon and the onions.
3. Add remaining ingredients. Mix thoroughly.
4. Grease 25 medium sized muffin or custard cups.
5. Add 1 tablespoon catchup to each mold and pack meat mixture over catchup.
6. Bake in a slow oven (300 F.) 45 minutes to 1 hour.
7. Serve with fried bacon or with bacon curls made as follows: Fry bacon slices until partly cooked but still limp. Stick tines of fork in one end of the slice and carefully wrap the bacon around the fork tines forming curls. Finish browning until lightly crisp. Serve with individual liver molds.

INDIVIDUAL VEAL LOAVES

Number Servings: 50		Size Serving: 1 slice (5x2 1/4 x 1 inch)	Total Yield: six 5 x 9-inch loaves
Ingredients	Amount	Ingredients	Amount
Ground veal	6 lb.	Eggs, slightly beaten	6
Ground pork	6 lb.	Salt	4 tbsp.
Chicken soup	1 1/2 qt.	Pepper	1 1/2 tsp.
Quick cooking oats	1 1/2 qt.	Onion juice	6 tbsp.
		Paprika	

1. Combine ingredients in the order given. Mix well.
2. Make into individual patties and pack on edge in 1 large or 3 (5x9-inch) loaf pans, making a solid loaf. Sprinkle with paprika.
3. Bake in a slow oven (300 F. to 325 F.) for 1 1/2 hours.

was cured meat or if salted crackers were used as a filler.

Chives or smaller quantities of garlic may be used in place of onion. Mace, marjoram, mustard, sage, curry, celery seed, caraway seed, nutmeg, allspice and cloves are a few suggestions for additional spices. Some spices are especially good for particular kinds of meat. Marjoram, caraway seeds and thyme combine well with the flavor of beef; marjoram, mustard, nutmeg,

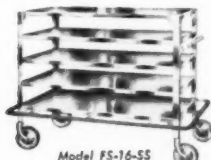
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curry, allspice, cloves and celery seed with veal; marjoram and sage for fresh pork; nutmeg, allspice and cloves for smoked pork, and marjoram, thyme, curry and mace for lamb.

Add—Other Ingredients

Cereals, cereal products, fruits or vegetables are usually added to ground meat in the preparation of loaves and patties. Rolled oats, oatmeal, rice; noodles, macaroni; whole wheat, enriched white or soybean bread; cracker crumbs; grated raw potatoes or carrots or mashed white or sweet potatoes,

and grated raw apple or applesauce are among the commoner ones. These ingredients serve as fillers or extenders and provide additional food value.

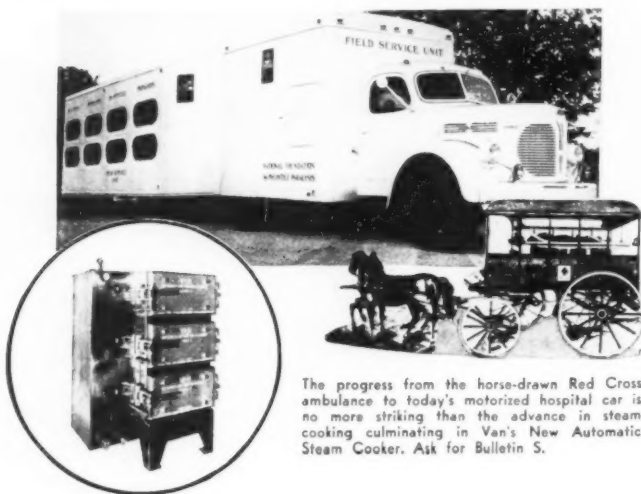
When an extender is used, it is necessary to add eggs or some other binder, including cream sauces. Besides basic cream sauces, those flavored with cheese are especially good. To keep the meat mixture moist and to help provide a juicy loaf, liquid should be added. Milk, water, canned or cooked tomatoes, catchup, soup stock, and meat stock are among the most popular choices.

Prepare—Muffins, Loaves, Patties

Because ground meats are tender and can be prepared in different shapes and varying weights, they are cooked by roasting, broiling, pan broiling or griddle broiling, braising, frying and even as a stew. Large loaves (round or oblong) are baked or roasted; meat muffins and casserole dishes are baked; patties may be baked, broiled, pan broiled or griddle broiled. However, fresh pork, veal or pork sausage are best when braised; meat balls are usually braised, and some ground meat is prepared as a stew—chile being an example. Croquettes are pan fried or deep-fat fried.

Ground cooked meats may be made into salad and jellied dishes or into meat loaves, patties and so forth, which are prepared by the same methods as the uncooked meats.

The important thing to remember in cooking ground meats, as in all other meats, is always to cook at low temperature. Meat loaves cooked at a moderate temperature are juicier and more attractive in appearance, shrink less, and therefore provide more servings. Meat balls, patties and other ground meat dishes are likewise juicier and better flavored.



The progress from the horse-drawn Red Cross ambulance to today's motorized hospital car is no more striking than the advance in steam cooking culminating in Van's New Automatic Steam Cooker. Ask for Bulletin 5.

Progress in Van's Century

- 1847 marked the start of a century of almost fabulous progress in medical science. The same years showed similar advancement in the science of kitchen engineering and the art of kitchen equipment fabrication . . . the century in which Van has pioneered for the industry.
- Hospital administrators and their architects regularly ask Van for suggestions when planning new projects, revisions or expansions of food service.

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FOOD FOR THOUGHT

New Flour

A new sweet potato flour has been developed by the Alabama Experiment Station. This is a fully cooked flour and differs in properties and uses from the flour made from dehydrated sweet potatoes. It is light yellow in color but when moistened turns to a deep orange brown. Cakes, muffins and soft cookies made with it do not dry out rapidly because the flour absorbs and holds moisture well.

It has been found especially good for fruit cakes, layer cakes, Southern brown bread, cookies, biscuits, muffins, icings and pies. In cakes it can be used to replace part of the eggs, butter and sugar at considerable saving in cost with improvement in flavor and texture.

Cakes that are prepared in this way have a rich creamy flavor, fine texture and grain and elasticity and hold moisture about twice as long as plain cakes.

Note to Hospital people:



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To the Dietitian: You should try Ac'cent. The nutritious food you serve speeds recovery of patients. And Ac'cent helps make those foods more appetizing, more enjoyable. It's a natural method of intensifying flavors. Ac'cent is not a "synthetic" product.

To the Chef: You should try Ac'cent. Good as your dishes are now, Ac'cent can make them taste even better. With Ac'cent you use your regular recipes. Just add Ac'cent. It brings out the best in your specialties, amplifies the fine results of your own skill.

To the Management: You should look into Ac'cent. It is good business . . . helps reduce the waste of untouched food, makes for more satisfied patients and personnel. Cost compared to benefits is low.

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Ac'cent

Ac'cent adds no flavor, aroma, or color of its own. A natural food-product itself. Ac'cent brings up natural food flavors. It helps in the preparation of nutritious dishes which have appetite appeal.

Ac'cent improves the taste of bland diets. Cooking helps to blur the raw, sharp profiles of many foods. Ac'cent helps further by emphasizing the desirable flavors.

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Ac'cent helps preserve flavors. It combats "steam table fatigue", helps hold flavors for longer periods.

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Menus for April 1949

B. Marilyn Olive
Drumheller Municipal Hospital
Drumheller, Alberta, Can.

<p>1 Tomato Juice Scrambled Eggs</p> <p>Canadian Pea Soup Broiled Halibut, Tartare Sauce Parsleyed Potatoes Buttered Green Beans Baked Lemon Pudding</p> <p>Cheese Soufflé With Chili Sauce Health Salad Canned Blue Plums Sugared Doughnuts</p>	<p>2 Stewed Rhubarb Soft-Boiled Eggs</p> <p>Potage D'Arblay Baked Sausages Apple Rings Whipped Potatoes Yellow Turnips Chocolate Sundae</p> <p>Spanish Rice With Diced Meat Celery Curis Strawberry Chiffon Angel Cookies</p>	<p>3 Half Grapefruit Bacon, Toast</p> <p>Clear Tomato Soup Roast Beef au Jus, Gravy Roast Brown Potatoes Cream Style Corn Cottage Pudding With Brown Sugar Sauce</p> <p>Eggs à la King Toast Points Tossed Greens Bartlett Pears Spice Cake</p>	<p>4 Apples Poached Eggs, Toast</p> <p>Alphabet Consommé Baked Pork Chop Escalloped Potatoes Hot Spiced Beets Custard</p> <p>Hamburger Patties on Half Roll, Gravy Green Tomato Pickle Coleslaw Canned Apricots Gingersnaps</p>	<p>5 Orange Juice Omelet, Brown Toast</p> <p>Vegetable Soup Bacon and Eggs Creamed Potatoes Dill Slices Deep Apple Pie</p> <p>Codfish Cakes With Tomato Sauce Spinach With Lemon Combination Fruit Salad Sponge Cake</p>	<p>6 Stewed Cinnamon Prunes Soft Boiled Eggs</p> <p>Barley Soup Salisbury Patties Mashed Potatoes Tomato Scallop Butterscotch Nut Blancmange</p> <p>Vegetable Chowder Large Cottage Cheese and Pineapple Salad Fruited Raspberry Gelatin Plain Rolls Jelly</p>
<p>7 Blended Juice Bacon Curis</p> <p>Onion Soup Braised Liver With Gravy Hashed Browned Potatoes Whole Carrots Creamy Rice With Jam</p> <p>Buttered Green Beans Tomato and Celery Scallop Glazed Parsnips Baked Apple Icebox Cookies</p>	<p>8 Orange Slices Scrambled Eggs, Toast</p> <p>Thick Vegetable Soup Salmon Loaf With Egg Sauce Washed Potatoes Buttered Broccoli Open-Face Peach Pie</p> <p>Macaroni and Cheese Shredded Carrot and Celery Salad Bran Muffins With Honey Stewed Blueberries</p>	<p>9 Prune Juice Fried Eggs, Toast</p> <p>Cream of Corn Soup Roast Loin of Pork Duchess Potatoes Peas Maple Ice Cream</p> <p>Beef Biscuit Roll With Gravy Turnip Sticks Boston Brown Bread Fresh Fruit Cup</p>	<p>10 Vegetable Juice French Toast, Sirup</p> <p>Minestrone Mixed Chops French Fried Potatoes Wax Beans Tapoca Cream</p> <p>Assorted Cold Cuts Potato Salad Stuffed Celery Strawberry Shortcake</p>	<p>11 Kadota Figs Shirred Eggs, Toast</p> <p>Potato and Leek Soup Corned Beef Steamed Potatoes Julienne Carrots and Turnips Rhubarb Crisp</p> <p>Crisp Bacon Asparagus au Gratin on Toast Grapefruit and Cherry Salad Chocolate Tarts With Whipped Cream</p>	<p>12 Tomato Juice Omelet With Jelly</p> <p>Canadian Pea Soup Poached Finnan Haddock Boiled Potatoes Harvard Beets Baked Bread Pudding</p> <p>Vegetable Pot Pie Tossed Green Salad Peanut Butter Cookies</p>
<p>13 Appleauce Soft Boiled Eggs</p> <p>Cream of Tomato Soup Swiss Steak Baked Potatoes Pureed Parsnips Marshmallow Sundae</p> <p>Chicken Noodle Soup Large Fruit Salad Plate: Cottage Cheese Pineapple Cakes Banana Loaf Frosted Grapes Citrus Fruit Sections Currant, Scones With Jelly</p>	<p>14 Fruit Nectar Poached Eggs, Toast</p> <p>Potage Breton Baked Stuffed Heart Mashed Potatoes Broiled Tomato Half Norwegian Prune Pudding</p> <p>Spaghetti With Meat Sauce Waldorf Salad Cubed Jelly on Meringue Shells</p>	<p>15 Apple-Lime Juice Multi-Colored Eggs</p> <p>Vegetable Soup Breaded Fillet of Sole French Fried Potatoes Parsleyed Carrots Lemon Meringue Pie</p> <p>Potato Chowder With Crackers Scrambled Eggs Tomato Relish Marinated Vegetables Tinted Pears Decorated Cup Cakes</p>	<p>16 Stewed Apricots Bacon, Toast</p> <p>Purée Mongol Meat Loaf With Catchup Potato Cakes Candied Yams Braised Celery Blueberry Pandowdy With Brown Sugar Sauce</p> <p>Cocktail Sausages Corn Fritters, Maple Sirup Carrot Curis Crabapples Gingersnaps</p>	<p>17 Grape Juice With Lemon Eggs in a Nest</p> <p>Essence of Tomato Soup Baked Ham With Cherry and Baked Bananas Candied Yams Buttered Broccoli Hollandaise Sauce Date Square à la Mode</p> <p>Chicken Pie With Vegetables Chopped Lettuce Salad Orange Charlotte Lady Fingers</p>	<p>18 Half Grapefruit Link Sausage, Toast</p> <p>Minestrone Roast Prime Ribs of Beef Franconia Potatoes Fresh Frozen Peas Deep Rhubarb Pie</p> <p>Luncheon Meats With Potato Chips Molded Vegetables Sliced Pickled Beets Hot Apple Pie</p>
<p>19 Fruit Compote Shirred Eggs</p> <p>Potage Longchamps Braised Tongue With Raisin Sauce Mashed Potatoes Cubed Turnips Plum Batter Pudding</p> <p>Dutch Potatoes Tomato Sauce Spring Salad Banana Trifle</p>	<p>20 Sliced Oranges Pancakes, Sirup</p> <p>Onion Soup Veal Stew With Vegetables Baked Potatoes Caramel Custard</p> <p>Bologna Cups, Hot Potato Salad Broiled Tomatoes Canned Peaches Crumb Cake</p>	<p>21 Apple Juice 3-Minute Eggs</p> <p>Consommé Julienne Roast Leg of Lamb With Gravy Green Jelly Escalloped Potatoes Parsleyed Carrots Chocolate Mint Blancmange</p> <p>Bacon Curis Sweet Potato and Almonds Apple and Celery Salad Grape Sponge Oatmeal Cookies</p>	<p>22 Tomato Juice Omelet, Sweet Rolls</p> <p>Scotch Broth Salmon Steak With Lemon Mashed Potatoes Lettuce Wedge, Thousand Island Dressing Pineapple Sherbet</p> <p>Cream of Tomato Soup Macaroni Salad Sliced Cheese Celery Stalks Raisins, Jam</p>	<p>23 Sliced Bananas, Cream Poached Eggs, Toast</p> <p>Vegetable Soup Cold Cuts Potato Patties Steamed Tomatoes Pumpkin Pie</p> <p>Baked Beans With Catchup Orange Slices With Lettuce Rye Bread Canned Bing Cherries Marmalade Cookies</p>	<p>24 Stewed Blueberries French Toast, Sirup</p> <p>Barley Broth Ground Steak With Mushrooms O'Brien Potatoes Whole Kernel Corn Butterscotch Sundae</p> <p>Ham Croquettes With Green Beans Tomato Aspic Fruit Cocktail Macaroons</p>
<p>25 Apples Scrambled Eggs, Toast</p> <p>Cream of Corn Soup Roast Loin of Pork Franconia Potatoes Green Peas Cream Pie</p> <p>Stuffed Green Peppers With Rice Pimiento au Gratin Veal and Onion Kabobs Celery Hearts Cubed Gelatine With Cream Peel Cake</p>	<p>26 Lemoned Prunes Country Sausage</p> <p>Canadian Pea Soup Braised Liver With Gravy Steamed Potatoes Mashed Turnips Lemon Snow With Custard Sauce</p> <p>Salmon and Codfish Mold Asparagus Tips Celery Hearts Cheese Biscuits Jelly Roll</p>	<p>27 Stewed Peaches Soft Boiled Eggs</p> <p>Tomato Soup Link Sausages Baked Potatoes Creamed Onions Old Fashioned Apple Tapoca Pudding</p> <p>Corned Beef Hash Hash Browned Potatoes Celery Sauce Beet and Egg Salad Canned Apricots Hermit's</p>	<p>28 Pineapple Juice Poached Eggs, Toast</p> <p>Potato and Leek Soup Roast Chicken With Dressing, Gravy Candied Sweet Potatoes Diced Carrots Nasty Pudding</p> <p>Cream of Tomato Soup Assorted Sandwiches Deviled Eggs Crisp Relishes Assorted Chocolate Cup Cakes</p>	<p>29 Grapefruit Juice Shirred Eggs, Toast</p> <p>Mulligatawny Soup Cottage Fried Potatoes Tomato Scallop Cherry Tarts</p> <p>Welsh Rabbit on Toast Combination Salad Raspberry Trifle</p>	<p>30 Oranges 3-Minute Eggs</p> <p>Split Pea Soup Hamburger Steaks With Mustard New Boiled Potatoes Buttered Beets Rice and Raisin Custard</p> <p>Bacon Curis Lima Beans With Creole Sauce Marinated Salad Greens Canned Peaches Brownies</p>

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Battle Creek and Omaha

Radiant Heating is practical for hospitals—Pryke

(Continued From Page 73.)

adequately. The salient features of the system have already been pointed out, and it will be seen at once that they meet the cleanliness and quietness conditions very well indeed. Complete absence of any exposed piping and lack of convection current drafts ensure absolute cleanliness, and a well designed system, with the correct hot water circulating pumps, is quite silent.

The effect of ceiling radiation on large glass areas, too, has already been dealt with. There are many instances, particularly in Switzerland, where the occupants of "open air" wards live in comfort even when the outdoor temperature is below zero. In fact, it is found that it is quite possible to keep French windows open on cold winter days and still maintain adequate comfort effect within the room. The new medical building at St. Bartholomew's Hospital, London, is a case in point. Here, the large wards have floor to ceiling fenestration, and the patients' beds are placed with the heads to the windows. On a cold, raw English winter day no discomfort is experienced.

From the evidence available, I believe it is well proved that radiant heating is a "natural" for hospital installations.

SPECIFIED FOR TB HOSPITALS

In the ten years prior to 1939, almost every large hospital constructed in England was radiant heated. In Sweden, Germany, Switzerland and Italy a similar situation existed. In Italy, particularly, under the state hospital program, radiant heating was specified automatically for all tuberculosis hospital buildings. It should be pointed out that in Sweden, Switzerland and certain parts of Germany, winter conditions are as severe as those normally encountered in the northeastern part of the United States, so that there is no question that radiant heating can adequately cope with our severest winter conditions here. Installations in Iceland with outside design temperatures of -20°F . have adequately demonstrated this. In view of the volume of the work abroad, it

seems a great pity that more attention has not been paid to the possibility of radiant heating in hospitals here.

Invariably there are certain questions which arise in the mind of the architect who has had no previous experience of radiant heating. These questions seem to follow a remarkably uniform pattern, and for some twenty years now I have been answering such queries as:

"Won't the plaster crack?"

"Won't the pipes corrode?"

"Is it practical to embed the coils in concrete slabs and plaster ceilings?"

"Is it practical to embed the riser mains?"

"What happens if there is a leak?"

"What happens when the pipes expand when the heat is applied?"

"How flexible is the system?"

These are some of the questions most frequently asked, although there are also a lot more with which I will not deal here.

In answering these queries, it may be relevant to quote from a report which was prepared by a consulting engineer in 1938 at the request of the Central Bureau of Hospital Information, which is a branch of the British Hospitals Association. He made a survey of some forty-two hospitals which had had radiant heating installations working from a maximum of twelve years to a minimum of one year. As regards plaster cracking, the report reads as follows:

"In the majority of buildings visited no cracks at all were visible, and the condition of the plastered surface over the embedded panels after several years' operation was as new, without sign of cracks. In certain instances cracks were discovered by close scrutiny, but these were confined to the skin of paint or distemper, arising generally from the use of unsuitable materials."

It must be remembered that the installations surveyed used field mixed cement plaster as is standard English practice, and it has been proved that the factory mixed gypsum plasters generally used here are considerably more stable with radiant heating than are

the European ones. Experience has indicated that with a correctly installed system and with proper initial operation with green plaster, no trouble results. Of course, the system must be run at low water temperature.

I have already dealt with the matter of corrosion, and I would only add that, with a properly embedded ceiling installation, I have found steel pipe of standard weight to be completely adequate in every respect.

CAN BE EMBEDDED

As regards the practicability of embedding pipe coils, there is no question of this as they can be arranged to be cast in the underside of practically any standard type of floor slab construction at present in use, so as to heat the rooms below. It is advisable to use a strong pipe for these coils so that they will withstand rough handling during the casting operation. In hung ceilings, where steel or wrought-iron pipe coils are used, they are directly secured to the main carrier channels, and the metal lathing is wired to them. Thus, they replace the usual furring channels. However, Type L copper tube may also be conveniently used in these locations and, owing to its small external diameter, can be secured beneath the metal lathing rather than above it. This makes plastering somewhat easier. Where coils are cast in, in large multistory buildings, there need be no interference with the flooring contractor's normal operations, although the laying and connecting up of the coils must be properly organized to synchronize with the contractor's program schedule.

The embedding of the riser mains follows the same general principles as the embedding of the coils and needs no further comment.

The question of leaks is directly associated with the matter of corrosion which has already been covered. The British Hospitals Association Report notes on this point:

"In no single case had it been necessary to effect any repairs to the embedded coils. It is not anticipated that the necessity will arise."

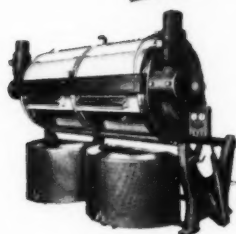
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It should be added that all embedded pipework should have welded joints and must be properly tested before casting in. If this is done, no leakage troubles will be experienced.

So far as expansion is concerned, there has never been any trouble experienced with this, when the system is operated at low temperature, with either cast-in or hung ceiling coils. Further, I have been personally concerned with several large installations in industrial buildings where no plaster was used, concrete surfaces being left exposed, and even in these cases no trouble was experienced with phasing of concrete surfaces covering embedded pipe coils.

Flexibility of the system is highly important, especially where rapid variation in outside conditions take place as happens in certain areas of this country. Experience has shown that when the proper type of controls is used a remarkably even temperature can be maintained internally, even with wide variations in outdoor temperature. In this connection, the type of building structure plays an important part, and the controls must be designed in relationship to this factor.

GIVE CONSTANT TEMPERATURE

Generally speaking, it can be said that with a concrete constructed building having the average type of external wall construction, the controls need not be of such a delicate nature as those required with a light frame constructed building having very large glass areas and thin external wood walls. However, even with the latter type of construction, modern controls, when properly applied, give a remarkably constant internal temperature. Certainly, with radiant heating more attention must be paid to controls than is the case with conventional heating systems, but it is possible to use the standard forms of controls and produce excellent results provided the control apparatus is properly applied.

In the larger installations for which we have been responsible, we have used a variable water temperature control, operating this from an outdoor temperature thermostat, and, in addition, we have also in some installations used individual room controls, these following the orthodox methods used with ordinary radiator heating systems. In two particular installations in fifteen-story buildings which we have been watching through this first winter's operations, we have obtained

quite good results with a combination of the two controls.

These particular installations are of what I term "heavy" construction. That is to say, the radiant heating coils are cast in the underside of the concrete slabs to heat the rooms below and are not, in general, in hung ceilings. We have found that the control problem is quite different with "light" construction, i.e. where the heating coils are in hung ceilings, than with "heavy" construction, as the response with the hung ceiling coils is much more rapid, of course, than it is with the cast-in solid slab coils.

As regards circulating pumps, the major problem here is one of noise, and absolute silence in operation of the pump is of vital necessity. In Europe special pumps have been developed for large radiant heating installations, but, unfortunately, we have not yet succeeded in getting the manufacturers to produce a special article for us. Generally, the pumps should be of low speed, with a relatively low circulating head, probably not more than 20 to 30 feet; and in order to achieve silence, they should be made with relatively large clearances between impeller and casing. This does not make for the greatest efficiency, but as the horse powers are small anyway, this is not of great import. The pumps should also be mounted on antivibration bases and be connected to the pipe work with nonmetallic couplings for large jobs. The importance of a silent pump cannot be overstressed, as a noisy pump produces the most unpleasant hum through the building, much more so with radiant heating than with hot water radiator heating.

I have not dealt, so far, with the question of the first cost of radiant heating installations in comparison with conventional radiator systems. It has been my experience that there is such a great variation throughout the country, owing to local conditions, methods of design employed, and materials used, that it is extremely difficult to give any general ruling on this point.

However, on large multistory buildings, I have found that costs run anywhere from 10 to 30 per cent over those of conventional systems. It must be remembered, of course, that in a hospital the heating contractor's work usually includes all the steam services required for sterilization and so forth. Therefore, the cost of the heating sys-

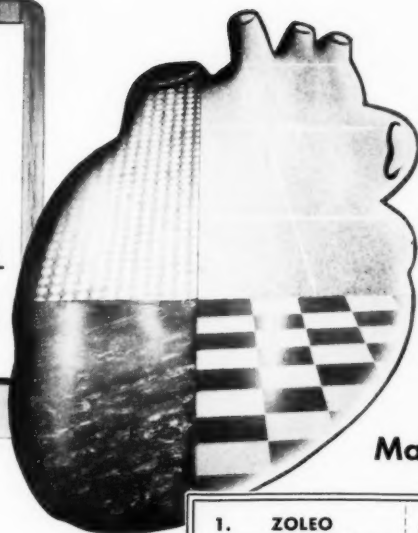
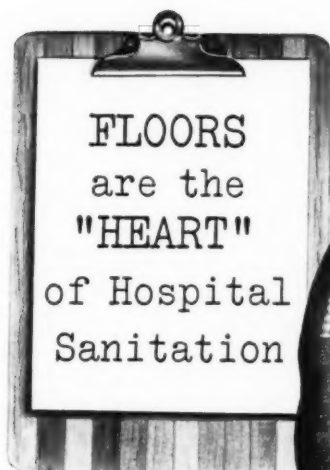
tem as such is only a proportion of the total value of the heating contract, and the actual cost increase of the radiant heating installation is not reflected as a direct proportion in the increase of the total heating contract.

In addition, the savings effected in architectural and interior decoration work by the installation of radiant heating are considerable and must be placed against the net additional cost of the heating system. These savings cover such items as lath and plaster work normally needed to cover steam risers, constructional work needed in connection with convector casings, painting of exposed pipe work and radiators, and furring channels in hung ceilings. Also in reinforced concrete buildings, it is often possible to use steel heating coils as reinforcement where they are cast in the underside of floor slabs and obviate the need for reinforcing steel rods. To evaluate truly the first cost of radiant heating, all these factors must be taken into account.

OPERATING COSTS LOWER

The operating costs of radiant heating installations in large buildings run between 25 and 30 per cent less than those for conventional systems. This is due to the small fuel consumption with radiant heating and also to the lesser amount of maintenance required. Prior to the last war, a test was run in England on the fuel consumption of two identical buildings: one was radiant heated and the other had a hot water radiator installation. Over one particular heating season, it was found that the radiant heated building used 43 per cent less fuel than did the radiator heated building.

In closing I would like to add a word of warning to those considering the use of a radiant heating installation. For completely successful operation, it is essential that the system be properly designed and properly installed. It is, therefore, of the utmost importance with large installations to employ experienced engineers and contractors. In this connection, the design of the system is even more important than is its correct installation. If handled correctly in this way, a radiant heating installation has every advantage and can give perfect results. However, wrongly designed and badly installed, a system can give very serious trouble indeed. Therefore, when using radiant heating always "Do it right or not at all."



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I WOULD like to discuss the outstanding elements of a good merit rating program. The first essential is that the support of top management be obtained. Although it is recognized that this is true of any function, it is of particular importance in the case of merit rating because the success of the program depends so directly upon the supervisors who will do the actual rating themselves. The traits selected to be used in the plan should be representative of the traits necessary in the employees being rated and should be pertinent to the type of work they perform. Suggestions and advice should be solicited from supervisors who will use the plan and who are most familiar with the personal requirements needed.

CANNOT RATE BOTH

It stands to reason that one merit rating plan cannot be used to rate both top executives and unskilled workers. If a broad range of employees is to be rated, separate plans should be designed. Objective factors, such as number of dependents and age, should not be included inasmuch as these factors do not contribute to an understanding of the employee's merit as a worker. The items or traits should be clearly defined, and the number of items included should not be so large as to be confusing to the rater or to overlap in meaning. The average number of traits used is from seven to ten.

Traits typical of many plans include quality of work, quantity of work, quality of judgment, learning ability, cooperativeness, dependability, application, initiative, neatness, accuracy, personal appearance, personality. Many firms assign weightings to traits in accordance with the relative importance they are felt to possess. The widely used merit rating plan developed by the National Metal Trades Association uses six traits with the following weights:

- | | |
|---------------------|-------------|
| 1. Quality of work | 25 per cent |
| 2. Quantity of work | 20 per cent |
| 3. Adaptability | 15 per cent |
| 4. Job knowledge | 20 per cent |
| 5. Dependability | 10 per cent |
| 6. Attitude | 10 per cent |

Each trait selected is then subdivided into degrees which represent all levels of performance on that trait. Too many subdivisions are confusing and make it difficult for raters to distinguish between the degrees. A survey conducted by Edward B. Green in "Measurements of Human Behavior" indicates that four or five subdivisions are most frequently used. Careful definitions or statements pertaining to the degree should be written. General terminology should be avoided.

Numerical values are then assigned to each degree. The over-all score is obtained by totaling the numerical value of each trait and placing employees in categories or levels of performance as designated by the total score. The National Metal Trades plan, for instance, uses five categories, each constituting a range of ten numerical points as follows:

- | | |
|----------------------|---------------------------|
| Group 1. 91-100 | Superior |
| Group 2. 81- 90 inc. | Good |
| Group 3. 71- 80 inc. | Satisfactory (or average) |
| Group 4. 61- 70 inc. | Slightly below average |
| Group 5. 60-below | Unsatisfactory |

It should be pointed out that the measuring of human traits and characteristics is even more difficult than is measuring job traits because human beings are infinitely more variable and

the traits characterizing an individual are not tangible as are the elements of a job. For this reason a merit rating program should be entered into with extreme care and study. It is often necessary to revise a merit rating form several times before a really satisfactory one is developed. Each merit rating program must fit the needs of the organization. It is not wise to adopt a ready-made merit rating plan unless it has been tested first for its validity and reliability in the particular institution. This can be done by comparing the results of merit rating with the results of employment tests and with the actual degree of success attained on the job.

MUST UNDERSTAND OBJECTIVES

A prerequisite to the success of any rating plan is that the raters understand its objectives and the elements of the plan itself. It should be pointed out that merit rating is not just a report card with which to check up on the employee but it has the broad purpose of building a strong organization by developing the employee. The specific uses of merit rating may include the following:

1. Determine the training needs of the institution by spotting weak points.
2. Assist in the selection of employees for promotion.
3. Assist in the transfer of employees to positions in which their skills can be more effectively utilized.
4. Make supervisors more aware of strong and weak points of employees and more personnel conscious.
5. Determine salary increases.
6. Motivate employees to greater effort.
7. Inform employee of his "standing" with supervisor.

Thorough training in rating employees should be given to supervisors. This can be done in conferences of small groups by explaining the plan and rating specific employees known

BOSTON UNIVERSITY PRESENTS

—The second section of the lecture on job evaluation, merit rating and salary administration which was presented at the extension course in executive housekeeping.



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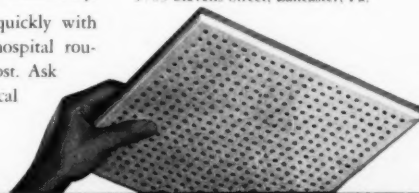
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to the group. It is essential to impress upon the raters their responsibility in rating individuals working under them because this rating determines the employees' monetary status and their opportunity for advancement through promotions. The necessity of eliminating personal likes and dislikes cannot be too strongly emphasized.

After the merit rating form is adopted and supervisors are trained regarding its purpose and use there are numerous questions of procedure that must be answered:

1. *How Often and When Should Employees Be Rated?* It is felt that employees should be rated at least once a year with the understanding that if an employee's performance so substantially improves or falls down as to require a special rating, it can be made upon request. However, it is felt that the majority of employees do not substantially change in the course of one year. In the John Hancock Life Insurance Company we rate all new employees at the end of six months and annually thereafter.

It is felt wise to have a company-wide merit rating program at specified times for several reasons: (a) If ratings of employees are made at the time of salary review, a tendency to rate high exists. (b) All employees in an organizational unit should be rated at one time because there is less likelihood that the ratings will be affected by day-by-day attitudes or moods of supervisors. For instance, if one employee is rated at the end of a steaming hot day when everything went wrong, he may receive a lower rating than did the employee who was rated on a spring morning when all was well. If employees are rated under somewhat similar circumstances, the ratings will be fairer. (c) Supervisors can more

readily compare ratings of all employees if they are rated at the same time.

The supervisor should rate all employees on each trait at one time and compare the relationships for all employees for each trait. The total score can then be compared to determine that the desired relationship is maintained. In this way there is less opportunity for unintentional bias in ratings.

2. *Who Is to Rate Employees?* The person who exercises closest supervision over an employee should be best fitted to rate him. The rater should know the employee and be in sufficiently close contact with him to be able to rate him fairly. However, owing to the highly subjective nature of the rating procedure, more than one person should rate an employee in order to increase the reliability of the results. At least two supervisors in close contact with an employee should rate him and the rating should be approved by a third person in the higher levels of authority.

3. *Are Ratings to Be Discussed With Employees?* Every employee has a right to know how he is making out on the job. If a supervisor has fairly rated an employee, he should not object to discussing the rating with him. This provides an excellent means of motivating the employee by pointing out in what specific ways he can improve his performance. If the rating interview is handled with tact and judgment, there is no reason to expect that undue difficulties will be encountered. A supervisor should approach the problem with a warm and sincere attitude; he should commend the employee on his strong points but he should be straightforward in discussing any weaknesses. He should urge the employee to express his opinions regarding the fairness and accuracy of the rating.

4. *Should an Employee Have the Right to Appeal?* A board of appeal should be set up with which an employee can discuss his rating if he feels he has been unfairly treated. Without this opportunity, it is expected that employees will express resentment.

At John Hancock, annual merit ratings are made in October. This month is selected because most vacations are over and the pressures of year-end work have not begun. It is felt desirable to select a time of low ebb of activity since much time and thought should be put into the ratings. Written instructions are sent out from the personnel department with the blank forms. These instructions are often discussed in groups with supervisors in an effort to obtain uniform ratings.

Specific problems and questions are discussed. This is considered a most important phase of the program because it is in this way that misconceptions or misunderstandings can be ironed out. The most variable aspect of any merit rating is, of course, the rater. It is often discovered that a certain rater may rate his clerks very low in relation to the company pattern. An analysis of the situation proves that he has done what he considered to be a conscientious job—but too conscientious. His concept of an "average" clerk was higher than the general interpretation applied by others to that indefinite term. He unwittingly scored his clerks low. In such cases an adjustment should be made. The opposite situation—that of having raters rate too high—is more usual.

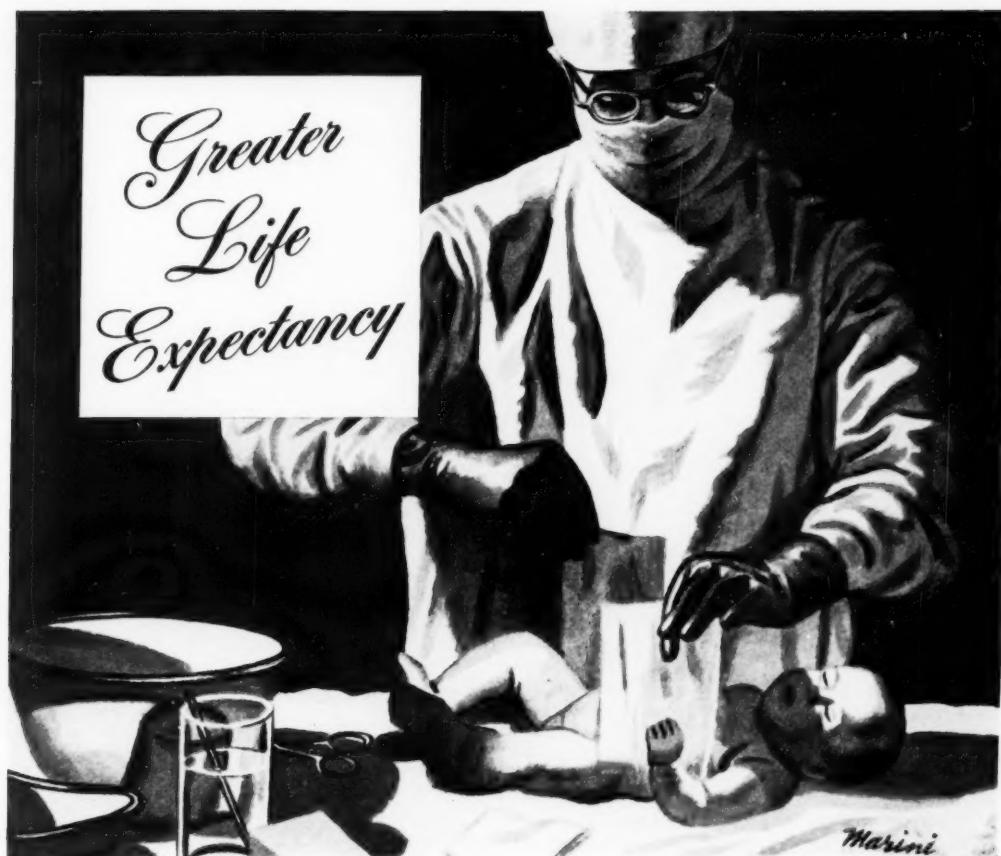
After both the job and the employee have been rated, a definite pattern of salary administration can be established. A chart should be made which sets forth the salary ranges of each labor grade and the amounts of increase within each grade. This amount of within-grade increase depends, of course, on the merit rating. In order to reward superior performance and to provide an incentive to perform better-than-average work, the within-grade increase schedule should provide for larger increases for superior and good clerks. This rewards the deserving clerks. It is only through such a schedule that uniformity can be maintained in granting increases throughout the organization.

Let us think of some of the other uses of job evaluation.

1. *Employment.* Good placement is fitting the person to the job. This

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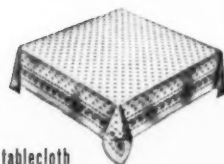
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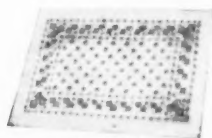
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can best be accomplished through job evaluation by using the detailed description of each job in the company. By analyzing the requirements of the job and the abilities of the applicant, a better job of placement can be done. Good placement is desirable not only from the monetary standpoint but from the standpoint of the satisfactions that will be derived from the job. Poor placement, irrespective of compensation, results in high turnover. If an incumbent is not given an opportunity to use and develop his skills, he derives no satisfaction from the job and either loses interest in it or looks elsewhere. Misplacement is one of the greatest causes of high turnover. For this reason a careful analysis of jobs within an organization should be made. If it is determined that the majority of jobs in a company are routine, only applicants of routine capacities should be hired to fill them.

2. *Hiring Rate.* After the employee is selected, the correct hiring rate must be set. If the hiring rate is improperly set, this inequity will be carried along throughout the service of the employee unless an adjustment is made. It is obviously unfair to hire two equally well qualified persons for the same job at different rates. In the absence of an organized pattern, this is quite likely to happen.

PRESSURES AT HIRING LEVEL

It is at this hiring level that pressures often come. Tight spots in the labor market exert pressure to distort the hiring schedule. Also, in many cases department heads are likely to quote rates to applicants based upon the amount designated as acceptable by the applicant. If authority for quoting hiring rates is not centralized, no uniformity can be expected. The employment office and the job evaluation division should work together in establishing standards or criteria for qualifications necessary for each grade of job, and written schedules should be used by any person authorized to quote hiring rates.

3. *Within-Grade Increases.* Once individuals are correctly placed and the initial rate of pay is determined, a policy must be made regarding the salary treatment which will be given incumbents as they gain length of service and increase in proficiency. A clear cut, concise policy regarding within-grade increases is desirable. There are those who think that once the job has been evaluated and a minimum

and maximum salary has been placed upon the job, that is enough. Gross inequities may occur in adhering to the maximums but in having no organized rate of progression to that maximum.

Within-grade increases may be given automatically or they may be based upon merit. It is felt that merit increases are desirable because they provide an incentive. Many labor organizations favor automatic wage progressions because they are suspicious of most merit plans. There is ample justification for suspicion of merit increases that are granted on the basis of favoritism and with no uniformity—as unfortunately many are. It is for this reason that if management wishes to maintain its prerogative of granting merit increases rather than being forced to grant automatic increases, it must establish orderly and defensible plans for uniform treatment to all employees of similar merit.

4. *Promotions.* I feel that one of the most important by-products of a job evaluation program is that of establishing a systematic promotional schedule. Many supervisors are not in the habit of thinking in terms of the real value and difficulty of a job and therefore have no definite promotional sequence. Job evaluation forces supervisors to think in terms of varying values of jobs and, consequently, to place the best employees in higher grade jobs.

In the past, many supervisors have placed their best employees in jobs simply because they needed to be filled rather than because they were more difficult. They may unwittingly have placed a monetary ceiling upon the employee by not thinking in terms of the ultimate monetary value of that job. Job evaluation, therefore, gives supervisors a tangible schedule of promotional progression. If a supervisor sees that a good employee is nearing her maximum, he should plan ahead and try to promote her to a job in a higher classification. In this way the exceptional and good employees will be given the opportunity to advance to higher jobs while the average or below average employees will remain on the lower class jobs.

Many companies pursue the policy of filling vacancies with qualified personnel from within the organization instead of hiring a new person. With such a policy eventually the only jobs to be filled by new personnel will be those of the lower level. This places es-

pecial importance upon promotions. The policy of promoting from within stimulates incentive. If employees know that they will be given an opportunity to advance to higher level jobs for which they are qualified, they strive to qualify themselves, both by their performance on the job and by acquiring additional qualifying skills through outside study. One of the most demoralizing situations in an employee's working experience is to have an outsider brought in and placed in a job to which the employee of some years' service hoped to be promoted. There are, to be sure, certain jobs which must be filled from the outside, but in many concerns the majority of jobs can be filled from within the organization.

HARD TO GIVE UP EMPLOYEES

This policy of promoting from within has its administrative difficulties but a clear cut policy may alleviate them to some extent. Interdepartmental promotions are easily effected; however, one of the chief difficulties is to have all department heads agree to the desirability of an interdepartmental promotional program and to cooperate in making it effective. It is understandable that a manager is unwilling to give up his best employee because a better job awaits her in another department. However, it must be pointed out to supervisors the unfairness of retaining an employee on a low grade job where she will soon reach her maximum. It should also be pointed out that an organization wastes potential if it does not develop and use the skills already existing within it. Also, employees of unusual ability will not remain satisfied if they are not allowed to utilize their ability and skills.

Inasmuch as no organization is static and, certainly, the individuals within the organization are not static, the task of constantly maintaining a job evaluation and merit rating program must be done. A periodic audit of all job descriptions should be made in order that any changes in jobs can be incorporated and reevaluations can be made accordingly. To be of any real use, the evaluation must be kept current and up to date. Department heads, therefore, should be instructed to inform the personnel department of all job changes. From this we can draw the conclusion that living up to the basic principle and slogan of job evaluation, namely, "equal pay for equal work," is indeed a full-time job.

What every hospital superintendent should know:



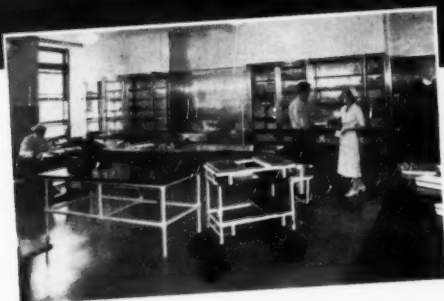
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Dental Service Unit

(Continued From Page 76.)

is desirable to have space for a limited number of patients in the dental area. A desk for the receptionist or clerk is necessary. Comfortable chairs for four or six patients are sufficient. Health education murals are suggested.

6. *Storage.* A small closet for supplies is necessary, in addition to other cabinet space shown.

7. *Administrative Offices.* No space is shown for administrative offices for the staff as it is assumed that such facilities will be supplied as required in other areas of the hospital, conveniently located. A desk for use by the dentist in preparing patients' reports is desirable as shown in the larger plan.

Record storage, public and employee toilets, restrooms, lockers and similar facilities likewise should be near by.

8. *Floors.* Floor covering will depend upon the type of construction and underflooring. Consideration should be given to the sanitary value, durability, factors of security, comfort and ease of repair. Linoleum, rubber, mastic, tile or cork is usually satisfactory. In any event, the operator will probably wish a resilient mat on which to stand. The laboratory floor should be resilient, grease and stain proof, and acid resistant.

9. *Walls.* Walls should be smooth finished, easily cleaned, and of light pleasing color. Health education murals have been suggested for the waiting room.

10. *Ceiling.* The ceiling should be acoustically treated, of similar color but lighter than the walls.

11. *Lighting.* For general illumination, baffled, nonglare lights are needed to provide 40 to 50 foot-candles around the dental chair, 25 to 30 over the dental cabinet, and 10 foot-candles in other parts of the room.

Surgical lighting is usually supplied as a part of the dental fixtures.

12. *Plumbing.* Acid-resistant piping is used for waste lines. Laboratory sink is of corrosive resistant materials. Exposed piping should be kept to a minimum. Outlets for hot and cold water, gas, air and vacuum are required. Roughing-in requirements may be obtained from any reputable dental equipment manufacturer.

13. *Ventilation.* Air conditioning is desirable and may be a part of the general conditioning system of the hospital or a unit just for the dental area.

14. *Equipment.* Suggested equipment lists are given in the "Check List of Equipment and Supplies" published in the 1948-49 edition of *The Hospital Purchasing File*. Since it is impossible to provide such a list to cover all requirements, the dentist should be consulted on a specific local problem. Items listed are sufficient for usual dental procedures.

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NEWS DIGEST

State Officers Gather for Mid-Year Conference . . . Include Nursing in Prepaid Plans, Nurses Ask . . . Urge Retention of Intern Appointment Plan . . . A.C.S. Approves 3150 Hospitals . . . Clyde Fox Heads Arizona Hospital Association

State Associations Don't Know Own Strength, Mid-Year Conference Is Told

CHICAGO.—State hospital associations should realize and exercise their organizational strength more effectively in dealing with official agencies, Dr. Martha O'Malley of the Indiana State Health Department told the Mid-Year Conference of State Presidents and Secretaries here last month. Dr. O'Malley told the association officials that their organizations were much more powerful



John V. Connorton, executive secretary, Greater New York Hospital Association, and Rosalie Castleberry of the A.H.A.

and influential than was commonly realized and that this strength could be used effectively to eliminate "fear of domination by official agencies."

Dr. O'Malley spoke particularly about the need for hospital association activity in connection with state licensing laws; such laws should provide some avenues of appeal to other than the official state agency, she said, recommending the creation of advisory or consulting boards representing state hospital associations.

Echoing Dr. O'Malley's opinion on the organizational strength of state hospital associations, Dr. Herbert Wortman, president of the New Jersey Hospital Association, urged the associations to study existing laws governing payments for indigent patients, looking toward maximum payment for hospitals under present laws and eventual improvement in the laws themselves. "Through their administrators, trustees and friends, hospitals have the power to get proper legislation and adequate pay-

ments if they will organize and act," Dr. Wortman declared.

The conference approved a resolution endorsing the recommendations of the Hoover Commission task force on federal medical services and urging the Congress to study legislation aimed at better coordination of federal hospital services in all branches. Particularly, the resolution, copies of which were to be



A. K. Parris, executive secretary of the Maryland-D.C.-Delaware group, and H. L. Wilson, Florida association president.

sent by the American Hospital Association to President Truman and Veterans Administrator Carl Gray, emphasized the importance of avoiding unnecessary and wasteful expansion of the Veterans Administration hospital system. "The association recommends that all hospitals in this expansion program be examined with care," the resolution stated, "even to the point of writing off such investments as may have been made for planning and real estate where it becomes obvious that such hospitals should not be constructed in the light of existing information. . . . The association is convinced of the need for close coordination of all the hospitals of the nation whether they be military, non-military, federal or nonfederal."

Considerable discussion during the conference was devoted to the national health program that has been proposed by the Truman administration. Speaking on this point, C. Rufus Rorem of

(Continued on Page 174.)

Medical Prepayment Plans Should Include Nursing Care, Nurses Assert

CHICAGO. — A plan to provide for nursing service under medical care prepayment programs was proposed at a meeting of private duty and general duty section officers of the American Nurses' Association here last month. The subject was discussed by Mary Collins, secretary of the joint committee on nursing and medical care plans of the association and the National Organization of Public Health Nurses.

Both national nursing organizations believe that nursing service should be included in medical care plans, Miss Collins stated. However, she added, these benefits would probably not be included in the voluntary plans until widespread public demand for such services is felt.

The continued shortage of nurses was attributed to the economic disadvantages of the profession compared with other vocations by one speaker at the meeting. John M. Falasz, Chicago attorney, said that graduate nurses in Illinois hospitals worked 207 hours a month for an average wage of \$162, or about 78 cents an hour, according to the Bureau of Labor Statistics for October 1946. At that time, he said, the average hourly wage of women in all types of manufacturing throughout the United States was 95 cents.

The nursing profession is making "little headway" toward providing the estimated 350,000 graduate nurses needed in the United States, Pearl McIver, A.N.A. president, told the conference. Although approximately 48,000 nurses will be graduated in the coming year, she said, the number still working will be only slightly more than 300,000 by January 1950. The demand for nurses is increasing constantly owing to changes in medical care and increases in hospitalization, Miss McIver said.



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NEWS...

Do Not Abandon Plan for Appointing Interns, Medical Leaders Warned

CHICAGO. — Hospital and medical school officials were urged not to abandon the plan governing internship appointments in a discussion held during the 45th annual Congress on Medical Education and Licensure here last month. Critics of the plan have suggested that it should be dropped because many hospitals violated provisions governing the procedure under which selection of interns is made by hospitals and appointments are accepted by interns.

However, Dr. Robin C. Buerki, vice president in charge of professional schools at the University of Pennsylvania, warned that abandonment of the plan would make the situation worse instead of better. Dr. Buerki and other speakers favoring retention of the plan pointed out that violations were inevitable because of the wide disparity between the number of available internships and the number of interns, and were not due to any weakness in the procedure, which was established jointly by the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges.

WOULD NOT SOLVE PROBLEMS

Abandonment of the internship plan would not solve the problem for hospitals that are having difficulty getting interns today, Dr. Harold C. Lueth, dean of the college of medicine at the University of Nebraska, told THE MODERN HOSPITAL during the congress. "Actually, it would make things worse," Dr. Lueth said. "If there weren't any plan at all, the big teaching centers and large hospitals would be likely to get an overwhelming majority of the interns, and middle sized and smaller hospitals would be even worse off than they are today." Dr. Lueth also attributed present internship problems of smaller hospitals to the fact that "there are nearly twice as many internships as there are interns today."

Cooperation of medical schools and local hospitals in regional programs to provide continued training for graduate physicians was recommended to the congress by Dr. Charles F. Wilkinson, associate director of the division of medicine of the W. K. Kellogg Foundation at Battle Creek, Mich. "Many medical

schools realize that to obtain their full growth they must expand beyond the campus and its ivory towers," Dr. Wilkinson said. "Hospitals far removed from university centers have been able to conduct improved intern and resident programs. Practitioners not in a university may have the stimulation that comes from training." He outlined the program which has been established at the University of Michigan, which emphasizes the fact that the best place for day-by-day stimulation of the practicing physician is in the hospital where he practices.

Among schools that have developed programs combining the need for daily postgraduate training and resident education, Dr. Wilkinson said, are Tufts Medical College, the University of Colorado Medical School and the New York University Medical School.

Connecticut Trustees Hold All-Day Session

NEW HAVEN, CONN.—Trustees representing a number of hospitals throughout the state met here last month in an all-day conference sponsored jointly by the Connecticut Hospital Association and the hospital administration section of the Yale University School of Medicine. The program featured a panel discussion of financial problems arising in connection with the care of indigent hospital patients in the state. Hiram Sibley, executive director of the hospital association, was coordinator of the panel which included three trustees and three administrators.

The trustees attending the conference also heard talks on community relations, accounting, medical education and hospital council activities.

Providence Plan Reports

PROVIDENCE, R.I.—Rhode Island Blue Cross had "increased membership, greater assets and lower operating cost during the last year," Kenneth D. MacColl, president, reported at the 10th annual meeting last month.

"We finished our ninth year of operation with a membership of 538,000 subscribers, compared to 518,000 in 1947," Mr. MacColl said. "This is an increase of 20,000 members and raises our coverage to 76 per cent of the state's eligible population—the highest coverage of any statewide Blue Cross plan."

College of Surgeons Approves 3150 Hospitals

CHICAGO.—The thirty-first annual hospital standardization report released last month by the American College of Surgeons lists 3150 approved hospitals in the United States, Canada and a few other countries at the end of 1948. Of these hospitals 2820 are fully approved and 330 are provisionally approved, the report stated.

A new development in hospital standardization applied for the first time in 1948 is the "Point Rating System," which was described by Dr. Malcolm T. MacEachern as an attempt to achieve precision in evaluating hospitals, with emphasis on the quality of professional services and care of the patient. Dr. MacEachern said:

"The enthusiasm with which hospitals have received the point rating system shows eagerness to raise standards by keeping up with advances in medical science, technology and social welfare ideals. The rating system will act as a stimulus to improve scores from year to year. Scores for each department or division and the total score are disclosed only to the hospital. Full approval represents a score of 70 to 100 per cent; provisional approval, 60 to 69 per cent, and not approved, below 60 per cent. The average score on surveys to date is approximately 75 per cent." Dr. MacEachern praised approved hospitals for notable progress in organization, control and efficiency.

Okay Bill to Give F.S.A. Cabinet Rank

WASHINGTON, D.C. — A bill which would create an executive department of public welfare with a secretary of cabinet rank was approved by the House committee on executive expenditures here last month. The bill would transform the present Federal Security Agency into a cabinet department and would group within this department federal services affecting public health, education and welfare. Representatives of the American Medical Association and the American Dental Association testified at commission hearings that health agencies should be separated from education and welfare functions in executive reorganization. They urged the establishment of a new cabinet agency that would deal exclusively with health matters.

Patients Recover Faster

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For many years, now, Acousti-Celotex has been bringing beneficial quiet into hospitals from coast to coast.

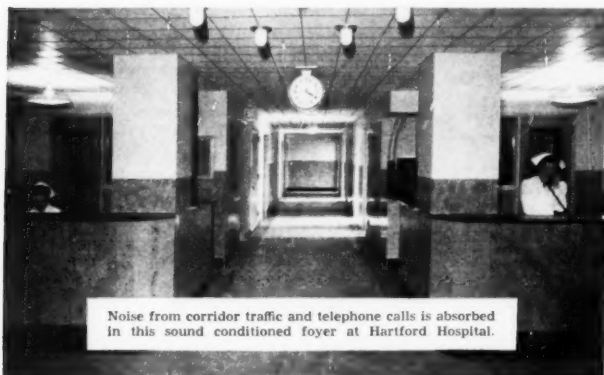
Your noise problem, too, can be solved quickly with this modern acoustical ceiling tile that can be *painted and washed repeatedly* without diminishing its high sound-absorbent efficiency.

Contact your nearest Acousti-Celotex distributor (United States or Canada) for a complete, free analysis of the noise problem in your hospital. Or write directly to The Celotex Corporation, 120 South La Salle Street, Chicago 3, Illinois.



ACOUSTI-CELOTEX
Sound Conditioning

PRODUCTS FOR EVERY SOUND CONDITIONING PROBLEM



Noise from corridor traffic and telephone calls is absorbed in this sound conditioned foyer at Hartford Hospital.



Hartford Hospital's diet kitchen is sound conditioned with Acousti-Celotex to quiet the clamor of preparing patients' meals.

NEWS...

Clyde Fox Named President of Arizona Hospital Group

PHOENIX, ARIZ.—Clyde Fox, administrator of the Tucson Medical Center, was named president of the Arizona Hospital Association during the annual meeting here last month. Guy Hanner, Good Samaritan Hospital, Phoenix, was reelected secretary-treasurer and Dr. Charles W. Sechrist of Flagstaff was named vice president.

Registration of the meeting totaled

more than eighty members of the growing association—making this the largest meeting in its history.

In a paper on hospital credit operations, Dr. Francis J. Bean, director of Pima County General Hospital, warned that many hospitals "either do not care or do not take the trouble" to distinguish between bad debts and true charity. Thus many hospitals are unable to state spe-



Left: Clyde Fox, new Arizona Hospital Association president; Right: Guy M. Hanner, reelected secretary-treasurer.

Blodgett Ovens

PREPARE 80% OF COOKED FOOD FOR TUBERCULAR INSTITUTION

Blodgett No. 959 Roasting and Baking Oven provides carefully controlled food for patients of Charles Cook Hastings Home, Altadena, Cal.

Proper diet and nutrition is the cornerstone of the cure of tubercular patients at the Hastings Foundation Home.

Since good and carefully controlled food is of paramount importance, it is not surprising that 80 percent of the Home's cooked foods are prepared in a Blodgett No. 959 Gas-Fired Combination Oven.

According to the Hastings Foundation:

"Blodgett Ovens show versatility in preparation of meals—a few of the foods cooked being roasts, deep dishes, meat loaf, fowl, custards, puddings, cakes, pies and rolls.

"Since December 1945, the beginning of our research in diet and better nutrition for patients, we have enjoyed fine performance and carefree service from our Blodgett baking and roasting ovens. For functional application, the Blodgett ovens have demonstrated their capacity to prepare better, more nutritious meals, and to permit efficiency in preparation of food."

ONE HUNDRED YEARS OF
THE G. S. BLODGETT CO., INC.
 50 LAKESIDE AVE., BURLINGTON, VERMONT

cifically what their charity loads are, Dr. Bean added, and are likely to include not only legitimate non-pay patients but also a number of accounts of patients unable to meet their obligations. In strict accounting, such patients should be considered bad credit risks or bad debts, he said.

A danger signal in hospital financial operation is the gradual increase from month to month of accounts payable, Dr. Bean told the group. "We all have to combat the tendency to put off until next month the payment of certain bills when the vendor is not pressing," he stated. "This is a danger signal which all good administrators should not allow to exist. Bills must be met and paid in spite of the leniency of many of our hospital supply industries. It is only good business and good public relations to meet our obligations to these firms just as we do with any other creditor."

Everett W. Jones, vice president of The Modern Hospital Publishing Company, Inc., said that the principal argument against federal compulsory health insurance was the fact that "so much of the fund would go to overhead and bureaucratic purposes and so little would be devoted to the needs of patients." Nevertheless, Mr. Jones declared, if medical and hospital groups do not cooperate in providing the kind of prepayment program the public is demanding, "they will have only themselves to blame when they get federal medical and hospital care legislation." He urged energetic support of Blue Cross and Blue Shield plans.

Other officers elected by the association were: trustees, Sister Mary Pius, Phoenix; Joseph Coppa, Kingman; Mother Anne Lucy, Tucson; Gerald Craig, Globe; Mrs. Antoinette Behrens, Safford, and Emmett McLoughlin of Phoenix.

**JELL-O
PEACH-ALMOND MOLD
SERVED IN LILY CUPS**

18 ounces Raspberry Jell-O
2 quarts hot water and peach juice (180°)
1 pint orange juice
1 teaspoon grated orange rind
1½ quarts canned, sliced peaches, drained
4 ounces toasted shredded almonds
Dissolve Jell-O in hot water and peach juice. Add
orange juice and rind. Chill till slightly thickened.
fold in peaches and almonds. Turn into Lily* cups.
Chill until firm. Serve plain or with whipped cream.

Yield: 48 3-oz. portions
36 4-oz. portions
29 5-oz. portions



**HERE'S
NEW APPEAL
FOR
ANY MEAL**

Now, here is a better, easier way to serve Jell-O—in sparkling Lily dessert cups! Compared with conventional nappies, Lily cups proved best by every test. Best for appearance! Best for speed! Best for economy! And even in hottest weather, Jell-O stays firmer longer in Lily cups.

Little wonder so many leading hospitals are switching to Lily Paper Service! Uniform, appealing, economical... and a blessing to overworked staffs. Save this recipe. Write today for additional recipes and for your free trial supply of Lily dessert cups. Then try these Lily Jell-O desserts yourself...and you too will be switching to Lily!

*T. M. Reg. U. S. Pat. Off.



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NEWS...

Methodist Hospitals Still Receiving Large Bequests, Executive Secretary Reports

CHICAGO.—The day of large philanthropic gifts is not over, Rev. Karl P. Meister, executive secretary of the Methodist Board of Hospitals and Homes, said here last month at the annual convention of the National Association of Methodist Hospitals and Homes. "Our hospitals received \$1,565,798 in large gifts last year," Dr. Meister said in his annual report as

secretary. "The largest gift was \$500,000. Two of our children's homes received \$1,000,000 each, and one institution received a gift of \$95,000."

Dr. Meister reported hospital expansion plans totaling more than \$23,000,000 in the Methodist group. The total assets of Methodist hospitals today are approximately \$119,000,000, he said. The seventy-one hospitals in the group cared for 496,061 inpatients last year at an average cost of \$11.34 per patient day, the report said.

At a meeting of the association's hospital section, Dr. Frank R. Bradley, Barnes Hospital, St. Louis, and George Bugbee, executive secretary of the American Hospital Association, took opposing views on the place of the federal government in the voluntary hospital system. Both speakers strongly opposed the federal compulsory health insurance program, which Mr. Bugbee said was administratively unworkable. However, Dr. Bradley objected to any kind of federal aid for any hospital or educational function, whereas Mr. Bugbee did not oppose federal aid for nursing education and other hospital purposes, provided the aid is allocated through states and controlled by local rather than federal agencies.

Reporting on the national hospital scene today, Mr. Bugbee said there was division of opinion about the feeling in Congress toward the national compulsory health insurance program. Many people think Congress will not approve any such legislation and that individual senators and representatives do not feel that last year's election indicated national sentiment in favor of the plan, Mr. Bugbee said. Nevertheless, he warned, this may be wishful thinking on the part of those who oppose the federal program. "My own opinion is that the majority in Congress believe the election did reflect national sentiment favorable to the health program," he said.

Dr. Bradley called for revision of the entire federal tax structure to stop the "trend toward socialism." He said that physicians favoring the federal program were mostly "inadequate personalities" who gravitated to research functions as an escape from the rigors of competitive practice.

Rev. E. C. McDade of the Bryan Memorial Hospital, Lincoln, Neb., pointed out that hospitals need no help from the federal government for nursing education, but cannot compete with federal hospitals for nursing service. At present, he said, voluntary hospitals are training nurses for the government; he urged establishment of government schools so that federal hospitals could train their own nurses. Only two or three of the hospital administrators present favored federal aid for nursing education, it was determined.

Rev. O. J. Carder, superintendent of the Missouri Methodist Hospital, St. Joseph, Mo., became president of the association.



How to win friends and influence nurses

To help solve the severe nurse shortage, progressive hospitals are doing everything possible to improve nurses' working conditions.

- A common complaint of nurses is the odor problem, which not only makes their daily work unpleasant but also cuts down efficiency.

- Many leading hospitals solve the problem of odors and stale air with Airkem Chlorophyll Air Freshener. They use Airkem in the familiar wick-bottle or the easy-to-service wall cabinet to counteract odors in small rooms. In larger areas,

hospitals are enthusiastically using the new portable Airkem Osmefans.

- Make your whole staff more comfortable, thus more efficient with Airkem. Give your patients odor-free air to help speed recovery. Welcome visitors to your hospital into Air of Quality. Airkem is an inexpensive, effective way to win friends for your hospital and increase its "nurse appeal."

- Order Airkem wick-bottles and mechanical equipment from your local Airkem representative or write to Airkem, Inc., 241 East 44th Street, New York 17, N.Y.



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Controls Odors Originating In:

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| 1 Odorous disease wards | 4 Operating rooms | 7 Freshly painted rooms |
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| 3 Autopsy rooms | 6 Lavatories | 9 Kitchens |

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You serve more meals at lower cost with a Garland because *every inch of a Garland works for you—efficiently*. You have a choice of four different models and a choice of top combinations on every model. You get the exact arrangement of open grate, hot top and griddle sections you need. Your chef can work faster without extra effort.

Garland is carefully engineered for speed, flexibility, and economical preparation of good food. And the largest production in the industry enables us to keep quality up and prices down. Compare — you'll find Garland has no equal.



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No. 84-3. Three hot top sections, two open grate sections with four giant open burners. Two ovens.



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*REG. U. S. PAT. OFF.



IN HOSPITAL FUND RAISING IS GOOD MEDICINE

RECENTLY the \$100,000,000 mark was passed in contributions to 98 hospital building funds entrusted to Will, Folsom and Smith, Inc., since Pearl Harbor . . . and evidence mounts of public willingness to support expansion that is soundly conceived and adequately presented. Specialized knowledge and skill gained exclusively in hospital finance over a generation have brought us invitations from large cities to pioneer in federated campaigns . . . but most of our practice will continue to be in average-sized communities where the bulk of hospital service is given. In our books, there is no minor surgery.



SMALL COMMUNITY HOSPITAL: At New Milford, Conn., \$400,000 was sought to replace an outmoded hospital, \$428,000 obtained. In Clinton, Mass., a \$275,000 completion fund to meet higher costs was exceeded. A \$150,000 campaign to enlarge the municipal hospital, Sidney, N. Y., reached \$211,000.



DENOMINATIONAL HOSPITAL: Mercy Hospital, Mount Vernon, Ohio, in a \$500,000 appeal, obtained \$557,000. A campaign for Mercy Hospital, Portland, Me., went \$53,000 past its \$600,000 objective. At Lawrence, Mass., a \$600,000 fund to establish the new Bon Secours Hospital reached \$1,113,000.



MILLION DOLLAR CLASS: The \$850,000 capital improvement program for Glens Falls Hospital, at Glens Falls, N. Y., resulted in a public response of \$1,105,000. Also exceeding the \$1,000,000 mark were successful fund projects at Chambersburg, Pa., Burlington, Vt., Winchester, Va., Concord, N. H.



SUBURBAN HOSPITAL: To enlarge the community hospital at Glen Cove, L. I., a \$1,750,000 fund was sought and \$1,796,000 subscribed. Perhaps an all-time per capita record is being set at Greenwich, Conn. Here a program for a new main unit is within \$190,000 of a \$3,750,000 goal.



URBAN HOSPITAL: Good news for York, Pa., came early this year as the \$2,000,000 campaign for a new wing and nurses' residence at York Hospital went \$574,000 past its objective. These lines are written as a fund-raising movement for the Memorial Hospital, Danville, Va., is nearing its goal of \$1,500,000.



MEDICAL CENTER: For the new Hartford Hospital, \$5,137,000 was obtained six years ago. As postwar costs rose, another \$2,300,000 was contributed. In the same city, St. Francis Hospital raised \$1,950,000. To these programs under our direction, \$9,387,000 was subscribed by a population of 200,000.

← Photographed at Harper Hospital,
Participating in \$19,720,000
Greater Detroit Hospital Fund

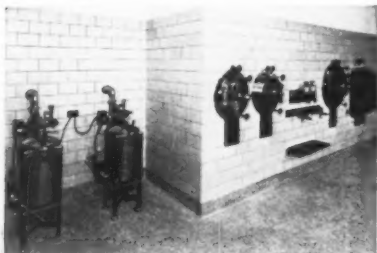
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126 NEWBURY STREET, BOSTON 16, MASS.

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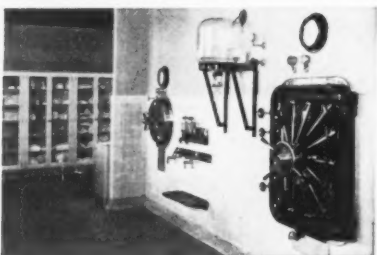
Scientifically Planned Central Service Rooms...

CASTLE engineers do continuous research on the problem of Central Service Rooms in the hospital. They are glad to consult with you on your particular requirements . . . to show you where and how to locate and equip your Central Service Room for maximum efficiency.

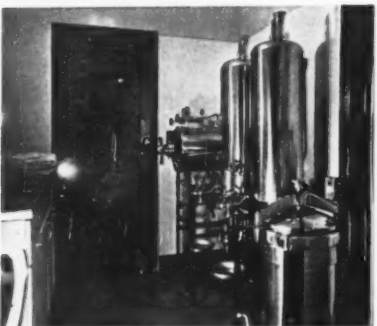
WRITE: Wilmot Castle Company, 1175 University Ave., Rochester 7, N. Y.



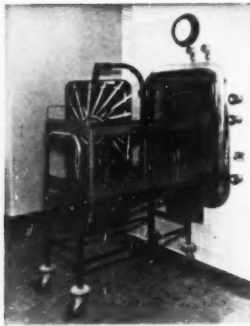
Central Sterile Service for Surgery, dry goods, sterile water, utensils and instruments. A specialized service designed for special needs.



Central Service Room with provision for bulk sterilization of dry goods and utensils and production of pure distilled water.



Central Sterile Service, installed between 2 surgeries, provides for washing and sterilizing instruments, sterile water, emergency sterilization of instruments.



General Supply Service for bulk sterilization of dry goods and utensils. Car and carriage safeguard technique and facilitate continuous operation.



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LIGHTS AND STERILIZERS

NEWS...

Bill to Amend Hill-Burton Act Introduced in Senate

WASHINGTON, D.C. — Amendments to the Hill-Burton Act were proposed in a bill introduced here last month by Senators Hill, Taft, Ellender and Smith and referred to the Senate committee on labor and public welfare. The bill proposes an increase in appropriations under the Act from \$75,000,000 to \$150,000,000 a year and extension of the term for five years following the fiscal year ending June 30, 1950.

Another amendment would permit adjustment of the federal allotment on each hospital project to make the federal contribution of one-third the total cost of the project apply to changing values throughout the period of planning and construction.

The bill would add a provision for "studies and demonstrations relating to coordinated use of hospital facilities." Under this provision the surgeon general of the Public Health Service would be authorized "to conduct research, experiments and demonstrations relating to the effective development and utilization of hospital services, facilities and resources, and, after consultation with the Federal Hospital Council, to make grants-in-aid to states, political subdivisions, universities, hospitals and other public and private nonprofit institutions or organizations for projects for the conduct of research, experiments or demonstrations relating to the development, utilization and coordination of hospital services, facilities and resources."

Cancer Film Available

NEW YORK.—A teaching motion picture aimed at reducing the death rate from cancer is now available to hospital staffs, medical schools, and groups of physicians in public health and private practice, the American Cancer Society announced here. The film was produced under the joint sponsorship of the society and the National Cancer Institute of the Public Health Service. It is the first in a series of six, to be produced within the next two years, designed to constitute a teaching package on the subject of cancer.

Prints for single showings may be had from state cancer society offices and state health departments, the announcement said.



see how Mosaic Tile costs you less!

Today you can install beautiful Mosaic tile at less cost than ever before—with Mosaic's fast, economical Lockart Method! For here is an exclusive process that permits direct application of tile right over plaster, brick, metal, concrete or plastic wall-board. You save time, money, labor. Application costs on new work are reduced as much as 30%. You'll save up to 40% on renovations.

new HARMONITONE line

Furthermore, only Mosaic brings you amazing *Harmonitone*—a remarkable new range of 36 glazed wall tile colors (1), color-coordinated with 24 unglazed floor tile colors (2), all chosen to harmonize with each other and provide a tile color range never before available.

No Metal Lath or Scratch Coat Required

When you specify Mosaic tile and the Lockart Method, no structural changes are necessary. There's no dirt—no mess. Moreover, shear tests conducted by the U. S. Testing Laboratories demonstrated that Mosaic tile, attached to plaster wall-board with the Lockart Method, withstands shearing pressure equivalent to about 2800 lbs. per sq. ft.

See how distinctive Mosaic tile is doing an outstanding job in remodeling, and on new work in many types of buildings. Use the coupon, consult your Mosaic dealer or your local Mosaic office. (See Mosaic folder in Sweet's Catalog.)

Sizes: (1) $4\frac{1}{4}$ " x $4\frac{1}{4}$ ", 6" x 6", 6" x 3".

(2) finished in usual ceramic mosaic sizes—posted about two sq. ft. to the sheet.

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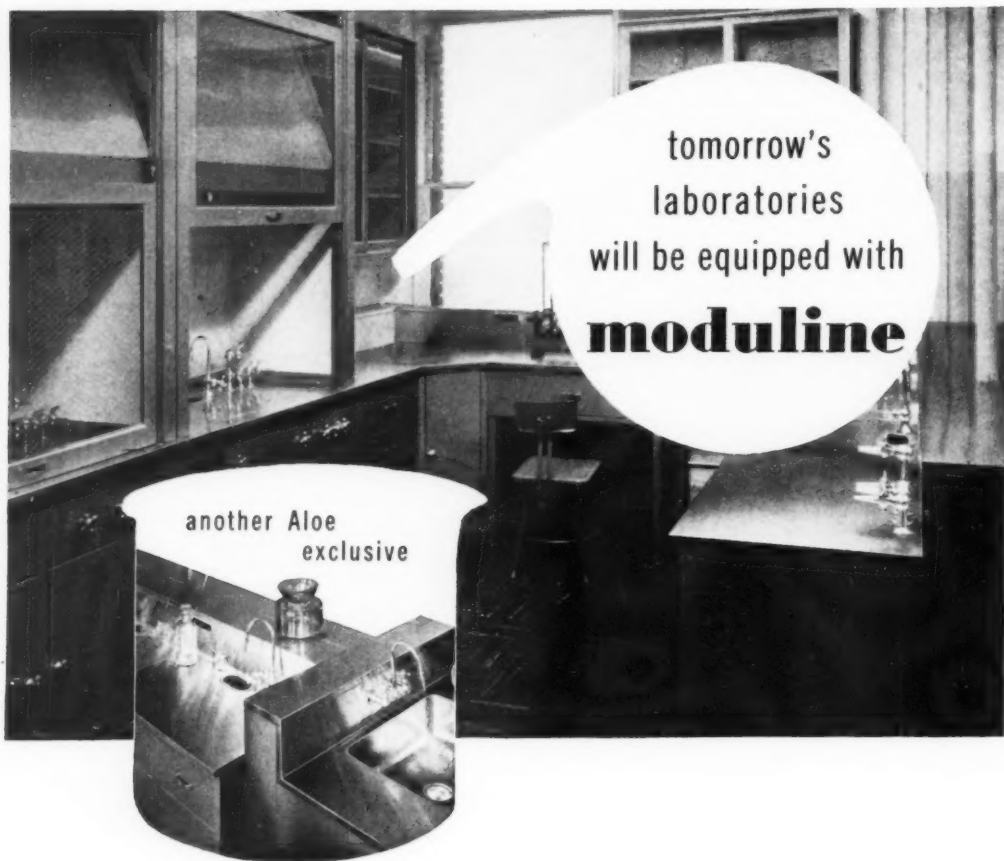
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Moduline, by Aloe, comes in architectural approved widths and depths so that custom-built laboratory facilities may be developed from standard Moduline units. Notice these details: concealed hinges; baked steel finishes with stainless steel table tops; Furnished with or without reagent shelves. Utilities can be top or splashback mounted. No working space is taken up with utilities. Each new installation is convincing more persons that Moduline is the most functional, practical, laboratory furniture ever designed. Write for special booklet T-300 and learn how Moduline can help solve your furniture problems.

Special schematic layouts for laboratories available on request.

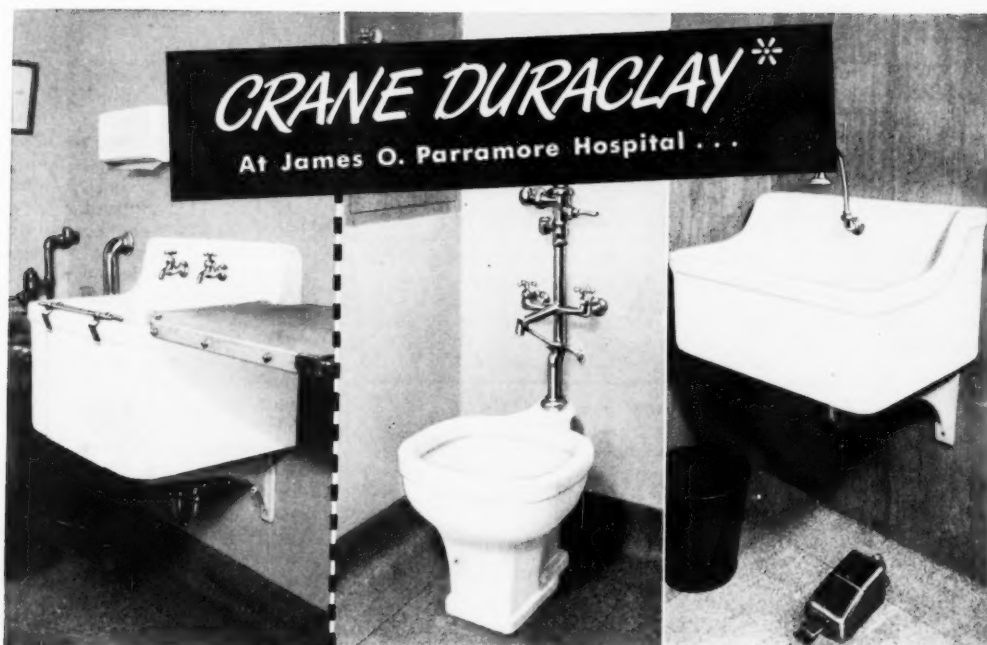
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Utility Sink of Crane Duraclay

Duraclay Flushing Rim Service Sink

Veteran of many years' hard usage, this Duraclay Scrub-Up Sink shows not a crack or craze.

THREE NEW HOSPITALS

Typical of the great development in the nation's hospital facilities are three outstanding new institutions — in Boston, in Newark, and in Omaha. Crane Co. is honored to report that all three institutions have chosen Crane plumbing, including Duraclay fixtures.

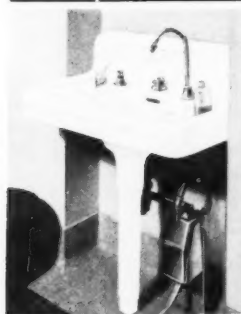
Some New... Some Old... but All unharmed by Thermal Shock!

No wonder hospitals that try Duraclay *once* insist on Duraclay *always*. They see how it stands up under extreme changes in temperature... how it remains unstained by strong acids... unharmed by bumps and jars.

Says Dr. Philip H. Becker, Medical Director and Superintendent of James O. Parramore Hospital, Crown Point, Indiana: "We have used Crane equipment for many years, and it has always given satisfactory results."

Entirely different from any other material used in hospital fixtures, Crane Duraclay is available in a complete line of hospital sinks and baths.

Your Crane Branch, Crane Wholesaler, or Plumbing Contractor will be pleased to tell you all about them. Meantime, write for your free copy of the Crane Hospital Catalog.



Besides the full line of Duraclay items, Crane supplies every plumbing need for patients' rooms, nurses' quarters, etc., plus a vast array of specialized hospital equipment. Crane Laboratory from James O. Parramore Hospital.

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NEWS...

A.M.A. Announces Program for Advancement of Medicine and Public Health

CHICAGO. — A twelve point program for advancement of medicine and public health was announced here last month by the American Medical Association. The program can be developed and administered "as a logical evolution from the existing institutions without bringing about chaos through complete overthrow of what has already been admitted by everyone to be the

highest quality of medical care available in any country in the world," the association stated.

The program has been developed over a period of years for the purpose of "charting a safe and sure road toward advancement of the nation's health," it was explained. Its provisions include creation of a federal department of health at cabinet level, federal aid for medical research in private institutions, further development of voluntary hospital and medical care plans, aid through

states to the indigent and medically indigent, establishment of medical care authority in states to receive and administer aid funds, development of hospital and health center facilities for rural areas, and expansion of public health services.

Other features of the program are: establishment of mental hygiene clinics, health education, provision of facilities for care and rehabilitation of the aged, integration of veterans' medical care and hospital facilities with other existing programs, increased emphasis on industrial medicine, and adequate support—"with funds free from political control, domination and regulation"—of medical, dental and nursing schools.

A.M.A. officials denied that its national campaign to fight compulsory health insurance involved any propaganda, lobbying or "slush fund" activities, as advocates of compulsory health insurance have charged. "We are not just working to beat a compulsory sickness insurance bill," Clem Whitaker, public relations director of the A.M.A. campaign, stated. "We are going to work together to resolve a program. We are going to do everything in our power to acquaint the American people with the desirability and the availability of prepaid, budget-basis medical care. We believe in voluntary health insurance, not just as a political expedient, but as a sound development in medical economics."

The program was described by Dr. Morris Fishbein, editor of the A.M.A. *Journal*, as the association's answer to a protest signed by a group of 136 A.M.A. members charging the A.M.A. with a "stand-pat" attitude in the face of federal proposals and "failure to develop a comprehensive, constructive health program."

TESTING . . . A FUND RAISING FIRM

The Hospital in need of financial service can test a professional firm by three measures:

- 1 Is the recommended program a sound one?
- 2 What is the firm's past experience in this field?
What has it accomplished for its clients?
- 3 Is it reliable?

There are nine fund raising firms established in the east that operate on a high standard of performance under a professional code of ethics.

There is ONE such firm in the West.

If you have a financial need, an inquiry will receive our careful attention. We will survey your situation and, based upon the findings, recommend a sound plan of procedure. Without obligation, of course.

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Vocational Nurses Graduated

ROCHESTER, MINN.—The first class of vocational nurse students was graduated from St. Mary's Hospital School here last month, Sister M. Domitilla, superintendent of the hospital, announced. Ten students received diplomas and heard talks by Sister Domitilla and Dr. H. K. Gray of the Mayo Clinic. Dr. Gray, who has taken an active interest in development of the vocational nurses' program, stressed the importance of auxiliary workers in caring for the sick.

Use the liquid in the can

NUTRITIONISTS have long recognized that extraction of vitamins and minerals occurs when fresh foods are cooked in water (1). They have further pointed out that discarding the cooking water—the usual home practice—entails a loss of valuable, essential nutrients (2, 3).

Modern practice in commercial canning goes far in preventing these solution losses in the case of products which are packed in syrups and brines.

Such canned foods are cooked by the heat process accorded them while still contained within the hermetically sealed can.

A minimum of water is used, which also

remains within the can, conserving for the consumer's use the extractable vitamins and minerals.

Tabulated below are vitamin values found in the solid and liquid phases of several canned vegetables (4). The results indicate that approximately one third of these vitamins are contained in the liquid portions. A parallel situation holds with respect to the minerals (5).

Physicians can effect a conservation of essential vitamins and minerals by urging housewives to serve the liquid in the can with the solid portion or use it in soups and gravies.

Percentage Distribution of Water Soluble Vitamins in Canned Vegetables

	Ascorbic Acid		Thiamine		Riboflavin	
	Solid	Liquid	Solid	Liquid	Solid	Liquid
Asparagus, green	60	40	62	38	71	29
Beans, green	64	36	67	33	76	24
Beans, Lima	56	44	68	32	76	24
Carrots	66	34	66	34	74	26
Corn, whole kernel	61	39	67	33	78	22
Peas	63	37	66	34	70	30
Spinach	62	38	69	31	76	24

(1) J. Home Economics 28, 15 (1936)

(2) Food Research 8, 115 (1943)

(3) Food Research 7, 300 (1942)

(4) J. Nutr. 28, 131 (1944)

(5) J. Am. Diet. Assn. 21, 354 (1945)

AMERICAN CAN COMPANY



230 Park Avenue, New York 17, New York

This is the third in a new series of articles which will summarize, for your convenience, the conclusions about canned foods, which authorities in nutritional research and canning technology have reached. We want to make this series available to you, and so we ask your help. Will you tell us on a post card addressed to the General Research Laboratory, American Can Company, Maywood, Illinois what phases of canned foods knowledge are of greatest interest to you. Your suggestions will help determine the subject matter of future articles.

The Seal of Acceptance denotes that the statements pertaining to nutrition in this advertisement are acceptable to the Committee on Foods and Nutrition of the American Medical Association.



NEWS...

Hospital Exhibitors and Associations Study Problems of Fund-Raising, Conventions

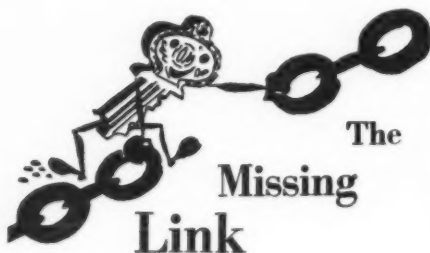
CHICAGO.—Representatives of hospital associations conferred with the executive committee of the Hospital Industries Association here last month to review the matter of solicitation of hospital industries for donations to individual hospital fund-raising campaigns, Edgerton Hart, H.I.A. secretary, reported.

"The trend in requests for donations to hospitals appears to be on the increase and has aroused the deep concern of our entire industry," Mr. Hart said. "This subject was fully discussed at a recent meeting of the executive committee in conference with hospital association officials. Representatives of the American Hospital Association and the Catholic Hospital Association expressed surprise and some concern at the problem as it apparently exists today." The industries association is circularizing its

membership to determine the extent of solicitation last year, Mr. Hart said.

The secretary's report also reviewed conferences with national and regional hospital association groups looking toward improvement in the conduct of hospital association conventions. These conferences covered steps to be taken in eliminating conflict among convention dates, scheduling convention meetings so that sufficient time remains for visiting exhibits, uniformity of badges, restriction of unauthorized visitors on the exhibit floor, use of loud-speakers and other noise-making devices in exhibits, registration and convention entertainment.

"The whole matter of the extent to which suppliers conduct large and costly cocktail parties in connection with conventions was thoroughly discussed with association representatives," the secretary reported. "It was realized that it is not correct procedure for either H.I.A. or hospital associations to regiment exhibitors or others in attendance at the conventions. However, there was a meeting of minds to the effect that some kind of control should be developed to eliminate as far as possible such large formal affairs."



between that period in the development of affairs when business letters were written in long-hand and records were kept mainly "in the head," and today's precise business-machine efficiency, is a small but vital item which many offices retain in an archaic state:

a system for the control of keys!



Saves countless man-hours of lost time—
Saves quantities of temper and trouble—
Saves locksmith and maintenance expense—

By retaining a reserve key, a pattern key which is never loaned—
By tagging and filing your keys as you mark and file records—
By recording each key's vital statistics in a foolproof control.

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NEW YORK 10, N.Y.



Ewing Will Address New England Group

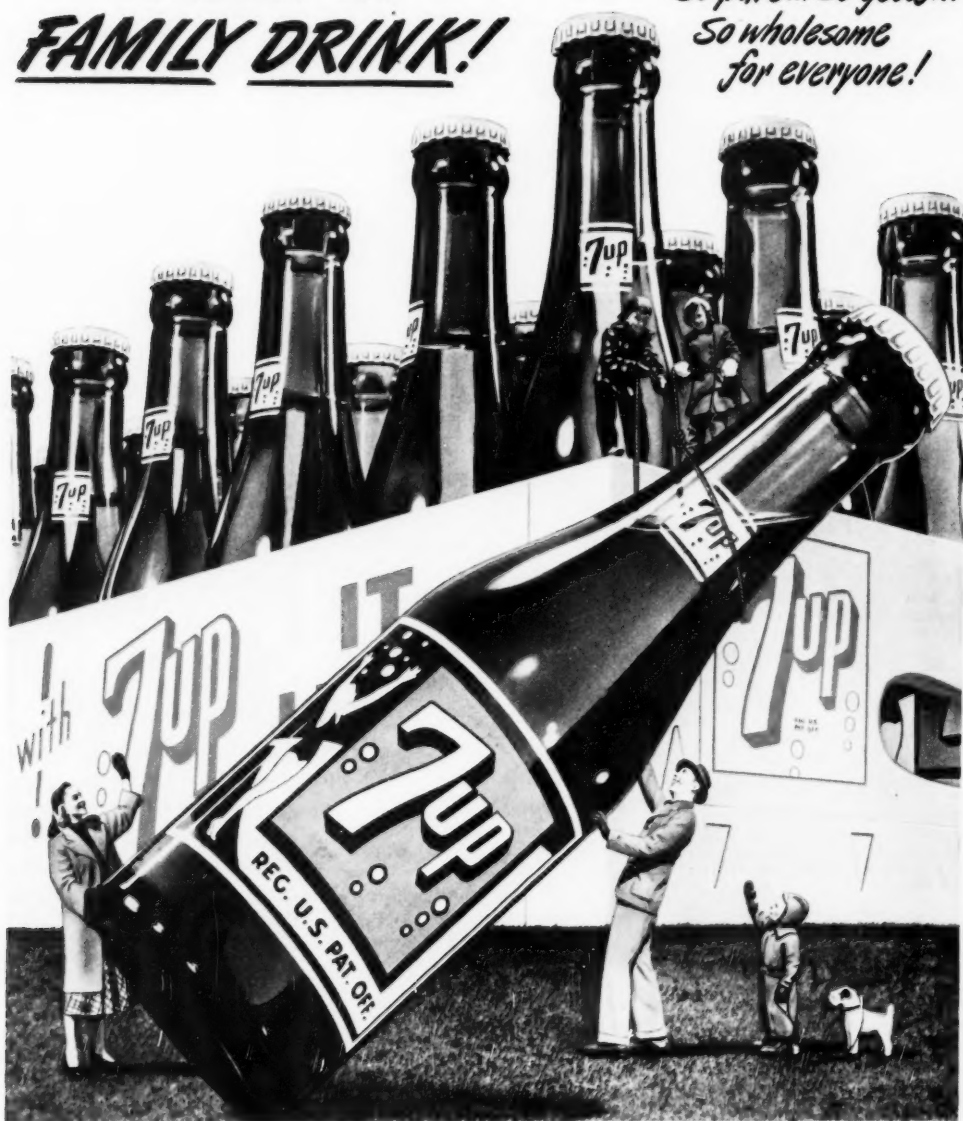
BOSTON.—Federal Security Administrator Oscar Ewing will be a featured speaker at the 26th annual meeting of the New England Hospital Assembly here, March 28-30. Paul Spencer of Lowell, secretary of the assembly, announced last month. Mr. Ewing will speak at a combined meeting of the assembly's trustee institute and general sessions on Tuesday, March 29, explaining how voluntary hospitals would be affected under the national health program proposed by the Truman administration. More than 1000 hospital administrators, trustees and personnel are expected to take part in the assembly, Mr. Spencer stated.

Hotel to Be Hospital

BROOKLYN, N.Y.—The Half Moon Hotel at Coney Island has been purchased by the Harbor Hospital here and will be converted into a hospital, it was reported last month. Hotel occupants will be evacuated by March 1 and the conversion into a 600 bed general voluntary hospital will be completed by June 1, the report said.

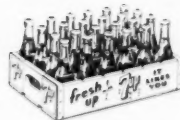
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NEWS...

A.H.A. Announces Five Institutes to Be Held in March, April and May

CHICAGO.—The American Hospital Association has announced five institutes for hospital trustees and administrative personnel to be conducted during March, April and May: the institute on management and operating procedures for the dietary department at Biloxi, Miss., March 14-18; the institute for medical record librarians, Buck Hill Falls, Pa., April 4-8; the institute for hospital engineers, Buck Hill Falls, Pa., April 11-15; the institute on hospital purchasing, Washington, D.C., April 18-22, and the institute on hospital laundry management, Chicago, May 16-20.

In addition, it was announced, an accounting conference will be held in Kansas City, Mo., April 25, 26, for members of the Mid-West Hospital Association.

Following are other American Hospital Association institutes definitely scheduled for 1949: pharmacy, San Francisco, June 27-July 1; dietetics, Los Angeles, June 20-27; purchasing, Ann Arbor, Mich., July 11-15; accounting (advanced), Boston, October 10-14; pharmacy, Chicago, August 29-Sept. 2; medical records, Biloxi, Miss., November 7-11; planning, Cincinnati, November 28-Dec. 2, and personnel relations, Chicago, December 5-10.

Would Bar Graduates of Foreign Medical Schools

CHICAGO.—Graduates of foreign medical schools would be barred from licensure examinations in all states under a recommendation made here by the Federation of State Boards of Medical Examiners. The recommendation was made in view of deterioration in medical teaching and equipment generally known to have taken place in most foreign countries since 1935, the federation explained. Purpose of the resolution embodying the recommendation was said to be to clarify conditions for foreign applicants and keep medical standards at a high level for the protection of the public.

Approximately 48 per cent of the 14,520 graduates of foreign medical schools examined by state boards in the United States from 1930 through 1947 failed to pass the examinations, Dr. Creighton Barker, secretary of the Connecticut board, told the federation. The figure did not include graduates of Canadian medical schools, he added.



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NEWS...

Brown Report Gives Impetus to Solving Nursing Problems

WASHINGTON, D.C.—The Brown report, "Nursing for the Future," has given an added impetus for collective action toward solving the problems of nursing service and education that are well known to nurses, hospital administrators and physicians, according to a statement issued by the Committee on Implementing the Brown Report. The statement was issued here last month by Mary C. Connor, chairman.

The committee represents the six national nursing organizations (National League of Nursing Education, American Nurses' Association, National Organization for Public Health Nurses, Association of Collegiate Schools of Nursing, National Association of Colored Graduate Nurses and the American Association for Industrial Nurses).

Miss Connor stated that, although the committee approved in principle Dr. Brown's recommendations, it is too early to offer any predictions as to

whether the future pattern of nursing education and nursing service will be along the lines portrayed in the report.

"The committee at the outset realized that in order to effect successful planning for a national program, all concerned with nursing service must have a voice in planning," the statement said, "and that hospitals, universities and others associated with nursing schools must actively participate if a mutual solution to the nursing problem is to be achieved.

"The report does not enumerate in detail the facilities or types of facilities in existence geographically. Since such detailed information is essential for sound national planning, the committee has appointed a subcommittee on school data analysis, which has sent questionnaires to state accredited schools.

"The success of this project depends on schools of nursing returning the questionnaire by March 10," the statement continued. "The importance of this project becomes significant when one considers that as a result of the collection and analysis of this information data will be on hand to initiate projects dealing with other aspects of our nursing problems.

"It seems fitting that the nursing profession should take the lead toward effecting an improvement in the nation's nursing service, but all concerned in nursing service should assume their part of the responsibility by contributing to the program. Active participation by hospitals, especially those closely associated with schools of nursing, is highly desirable and all hospitals will certainly be benefited in the long run."

Hospitals receiving the nursing school questionnaire can help themselves as well as other hospitals and nursing schools by promptly completing and returning the questionnaire form, Everett W. Jones, vice president of The Modern Hospital Publishing Company, Inc., said in an accompanying statement. The project has been endorsed by the council on professional practice of the American Hospital Association. Mr. Jones said.



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Seminar on Hospital Program

WASHINGTON, D.C.—Nineteen states and three Latin-American nations were represented at a seminar on hospital planning and construction held here last month by the Public Health Service, Division of Hospital Facilities.

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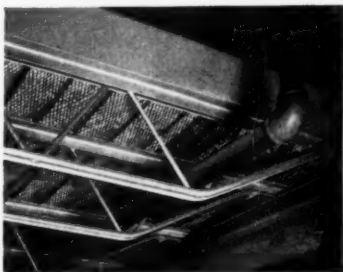
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NEWS...

MacEachern Announces Names of N.U. Students Qualified for Degrees

CHICAGO. — Dr. Malcom T. MacEachern, director of the program in hospital administration at Northwestern University, announced that the following students qualified for degrees last month: Lawrence Brett, master of hospital administration, administrator, Lexington Memorial Hospital, Lexington, N.C.; Eileen G. Damiani, B.S. in hospital administration, administrative internship at

St. Luke's Hospital, Chicago; Haydn M. Deaner, B.S. in hospital administration, assistant administrator, Truesdale Hospital, Fall River, Mass.; Harry O. Dudley, master of hospital administration, administrative assistant, Mount Sinai Hospital, Chicago; Charles E. Mattix, B.S. in hospital administration, administrative internship at Grace Hospital, Detroit; George B. Pearson, B.S. in hospital administration, administrator, Highland Sanitarium, Shreveport, La.; Edwin H. Prescott, B.S. in hospital administration,

assistant administrator, Williamsport Hospital, Williamsport, Pa.; James A. Robinson Jr., master of hospital administration, administrative residency at Los Angeles County Institutions; Thomas B. Sellers Jr., master of hospital administration, administrator, Old Hermann Hospital, Houston, Tex., and Manley C. Solheim, B.S. in hospital administration, administrative internship at Charles S. Wilson Memorial Hospital, Johnson City, N.Y.

The following one-year administrative residency appointments were announced, effective February 1, for students who finished the academic portion of the courses: William L. Anderson, Grace Hospital, Detroit; Mansfield Beshears, Presbyterian Hospital, Chicago; Evelyn M. Millis, Westlake Hospital, Melrose Park, Ill.; Ralph L. Roy, Methodist Hospital, Memphis, Tenn., and Ernest A. Ryberg, St. Luke's Hospital, Chicago, for six months followed by six months at Sherman Hospital, Elgin, Ill.

Change Name of Hospital

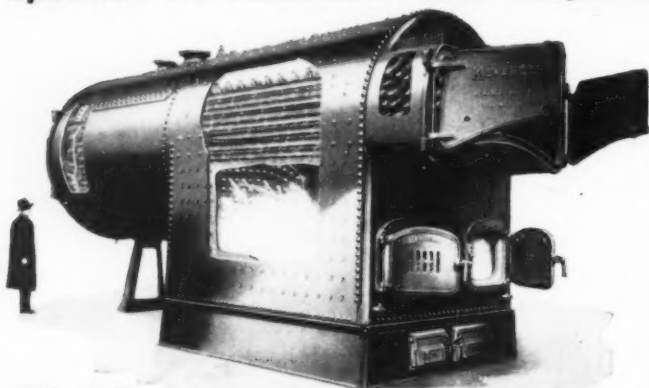
BOSTON.—The hospital unit of the New England Medical Center will be known as the "New England Center Hospital," Richard T. Viguers, administrator, announced last month. The hospital corporation operates the Joseph Pratt Diagnostic Hospital and the Ziskind Research Laboratories and will also include a new surgical hospital, Mr. Viguers explained.

"The individual units will continue to use their old names but in referring to them as a group and also for certain formal purposes, the new name will be used," Mr. Viguers explained. "This change is a change of name only and has no other significance."

Campaign Totals \$1,338,545

ERIE, PA.—The St. Vincent's Hospital expansion campaign was concluded here last month with a record-breaking total of \$1,338,545 subscribed. Of this amount, \$400,000 will be spent for an addition to the nurses' home, \$350,000 will go for a new food service building, \$250,000 will be used to pay the balance due on the general modernization of the main building just completed, and \$100,000 will be spent for a new maintenance and storage building, the hospital announced. The campaign was directed by Ketchum, Inc., and was carried on over a period of three months.

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A "SPONGE-STICK" SPONGE. RONDIC Sponges are suitable for use with "sponge-stick" or sponge forceps in any field of surgery. They have been used successfully in abdominal surgery, vaginal and rectal repair, etc. In any situation where a "sponge-stick" is used, RONDIC Sponges are ready for use.

Other uses are myriad, in all departments. Some of them are:

Tensil sponge and pack.

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Hypo, intravenous or hypodermoclysis wipe.

Any "sponge-stick" use on the floor, dressing carriages, in the laboratory, examining or emergency rooms.

SAVE VALUABLE NURSE-TIME. RONDIC Sponges, the first ready-made ball-type sponge, release nurses for vital professional duties. The advantages of other ready-made dressings (such as CURITY Gauze Sponges, LISCO^{*} Sponges and RADIOPAQUE^{*} Sponges) are known to all hospitals. Now the same advantages may be enjoyed on round sponges.

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NEWS...

Conservatives Call British Health Plan a Failure, Demand Bevan's Resignation

CHICAGO.—Spokesmen for the Conservative party in Britain's Parliament charged that the Socialist government's health scheme was a failure and demanded the resignation of the health minister, Aneurin Bevan, according to a report published here last month by the *Chicago Tribune*. The health service was estimated to cost \$529,700,000 up to

March 31, the report said, but the House of Commons approved appropriation of an additional \$211,200,000. Conservative speakers charged the government with "deliberately" underestimating the cost of the plan in order to sell it to the public, the *Tribune* report stated.

Speaking for the health ministry, Arthur Blenkinsop, secretary, said the government had no means of judging the plan's cost in advance. Under its first nine months of operation, he re-

ported, 128,000,000 prescriptions had been filled, 2,000,000 pairs of spectacles were provided, and 2850 artificial limbs had been distributed.

A New York *Times* report of the same debate said government speakers reported that nearly a fourth of the extra expense incurred during the plan's operation, in excess of original estimates, was caused by a rush for long-neglected dental treatment. According to this report, Mr. Bevan and Mr. Blenkinsop insisted that the plan was working successfully and was "the most popular program ever undertaken by any government." The ministry said that 95 per cent of the population had registered for treatment from general practitioners and that "the vast majority of practitioners" had joined the service. Ninety per cent of the nation's dentists also are participating, it was reported.



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Montefiore Hospital Starts "Family Interview" Program

NEW YORK.—Montefiore Hospital for chronic disease here has instituted a "family interview" program aimed at answering questions and allaying fears among relatives of hospital patients, it was reported here recently. Two evenings a week are set aside during which, at stated periods, teams of staff physicians and social workers are available to discuss problems arising from the illness of hospital patients with members of the patients' families. The interview program was described by a New York *Times* writer as "another innovation by Montefiore Hospital, a pioneer in the technics of institutional medicine."

Commenting on the program, Dr. E. M. Bluestone, hospital director, said the interviews provide "a stereoscopic view of the patient," combining social and medical aspects and enabling both medical and social staffs to learn more about the patients' problems at the same time, it was explained. The program permits the family of the patient to discuss the situation with staff members without pressure and in a relaxed atmosphere.

Interviews commonly last from ten to twenty minutes, it was reported. No appointments are made and no limit is set on the number of visits with the doctor and social worker that each family may have. Interviews take place in the hospital auditorium every Tuesday evening for one hour preceding regular hospital visiting hours.

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NEWS...

Introduces Prepayment Plan for Hospitalization of California Workers

SACRAMENTO, CALIF. — A state prepayment plan for hospitalization was proposed here last month by Francis Dunn Jr., Oakland assemblyman, who presented a program to cover 3,000,000 California workers in a voluntary hospital plan that would be integrated with the existing unemployment system. The Dunn plan would add a 1 per cent pay roll deduction on the first \$5000.

"Not all workers would join at first," the assemblyman explained, "but as benefits were demonstrated others would join and in the meantime hospital facilities would be expanded to care for the increased load."

Mr. Dunn opposed Governor Warren's bill for compulsory state health insurance. "It is doubtful if any compulsory program can be made to work even if it were possible to enact the law," he said. "For one thing, we do not have sufficient hospital facilities to take care of

everybody; furthermore, it is my opinion that for any hospitalization plan to succeed we would have to have the full cooperation of the doctors, who now oppose compulsory health insurance."

COMING MEETINGS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Cleveland, Sept. 25-26.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Southern Institute, University of Tennessee College of Medicine, March 21-26.

AMERICAN COLLEGE OF SURGEONS, Sectional Meetings: Statler Hotel, Washington, D. C., March 15-16; Statler Hotel, Buffalo, N.Y., March 21-22; MacDonald Hotel, Edmonton, Alta., April 12-13.

AMERICAN CONGRESS OF OBSTETRICS AND GYNECOLOGY, Hotel Statler, New York City, May 14-19.

AMERICAN HOSPITAL ASSOCIATION, Cleveland, Sept. 26-29.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Book-Cadillac Hotel, Detroit, Aug. 23-25. Institute, Aug. 26, 27.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Cleveland, Sept. 23-24.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Hotel Roanoke, Roanoke, Va., June 20-23.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, San Francisco, June 5-10.

ARKANSAS HOSPITAL ASSOCIATION, Marion Hotel, Little Rock, May 14-17.

ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION, Hotel New Yorker, New York City, May 18-21.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, May 9-12.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Asheville, N. C., April 21-22.

CATHOLIC HOSPITAL ASSOCIATION, St. Louis, June 13-16.

IOWA HOSPITAL ASSOCIATION, Fort Des Moines Hotel, Fort Des Moines, April 22.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, March 20-April 1.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, duPont Hotel, Wilmington, Del., Nov. 14-15.

MASSACHUSETTS HOSPITAL ASSOCIATION, Statler Hotel, Boston, March 28.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 18-20.

MID-WEST HOSPITAL ASSOCIATION, Kansas City, April 26-28.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 28-30.

OHIO HOSPITAL ASSOCIATION, Nell House, Columbus, Ohio, March 23-26.

SOUTHEASTERN HOSPITAL CONFERENCE, Buena Vista Hotel, Biloxi, Miss., April 27-29.

SOUTHERN CONFERENCE ON HOSPITAL PLANNING, Biloxi, Miss., May 19-21.

TENNESSEE HOSPITAL ASSOCIATION, Andrew Jackson Hotel, Nashville, March 17-19.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, April 19-21.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-4.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis, May 26-28.

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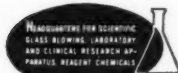
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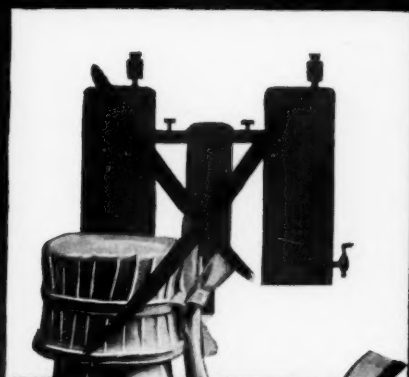


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Vol. 72, No. 3, March 1949





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NEWS...

G.P.'s Protest Ruling of Maimonides Hospital Requiring Specialization

BROOKLYN, N.Y.—A reorganization of the medical staff at the Israel Zion Division of Maimonides Hospital here under which 300 general practitioners would have to limit their hospital practice to one department was strongly protested last month by spokesmen for the general practitioner group. The general practitioners contended that it was "either medically or economically impossible" for them to specialize and that the regulation was therefore equivalent to loss of hospital privileges. The move was also described by the doctors' group as a loss to the public since patients of the doctors affected would be denied the full use of hospital facilities, it was claimed.

Hospital officials denied the charge and said the reorganization was in line with staff structures in "practically all the large voluntary hospitals of the city." The changes were described as part of a comprehensive development program at the hospital aimed at bringing better and more economical care to Brooklyn residents.

"Under the new plan, which also includes expansion and renovation of facilities, intensification of medical education and institution of a larger research program, there is a place on the staff for every member now on it," a hospital official said. "If these doctors choose to leave the staff, it's their own doing."

Under the original reorganization plan, general practitioners using the hospital's facilities were requested to choose a single field—either medicine, surgery or obstetrics—by July 1, 1948. The doctors appealed to the hospital for additional time and the date has been extended to July 1, 1949, it was explained. The doctors' group is now requesting continuation of present status for an additional five years.

\$2,000,000 to Detroit Fund

DETROIT.—Contributions of \$1,500,000 by the Kresge Foundation and \$500,000 by the McGregor Fund have been made to the Greater Detroit Hospital Fund, it was announced here last month. The fund will finance enlargement and modernization of ten voluntary hospitals and construction of four new ones in the Detroit metropolitan area, it was explained.

What every Hospital Administrator should know about

MICARTA

Micarta is ideal for counter tops in lunch-rooms and soda shops. It is not marred when cigarettes are snuffed out against it.

*If you are uncertain,
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Here's a challenging offer:

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Use silverware, cooking implements, the ordinary tools that would be used in a busy kitchen or pantry. Just try!

Try to dent it!

Bang heavy glasses, ash trays, cups, or even cooking pots and pans on it. Just try!

Try to stain it!

Spill alcohol on it, boiling water, nail polish, polish remover, even hydrogen peroxide up to 8 hours. Just try!

Try to score it!

Gouge it with the edge of a half dollar. You can, of course, scratch it with the point of a sharp steel penknife, but as for anything else, just try!

Try to spoil it!

Use it as an ash tray. Snuff out cigarettes against it. Walk on it. Actually *boil* it in water. Just try to spoil it.



Micarta table tops offer a tough, impervious surface that makes possible "hospital cleanliness." Sanitation is quite as important in hospital eating places as in operating rooms, where Micarta is extensively used.

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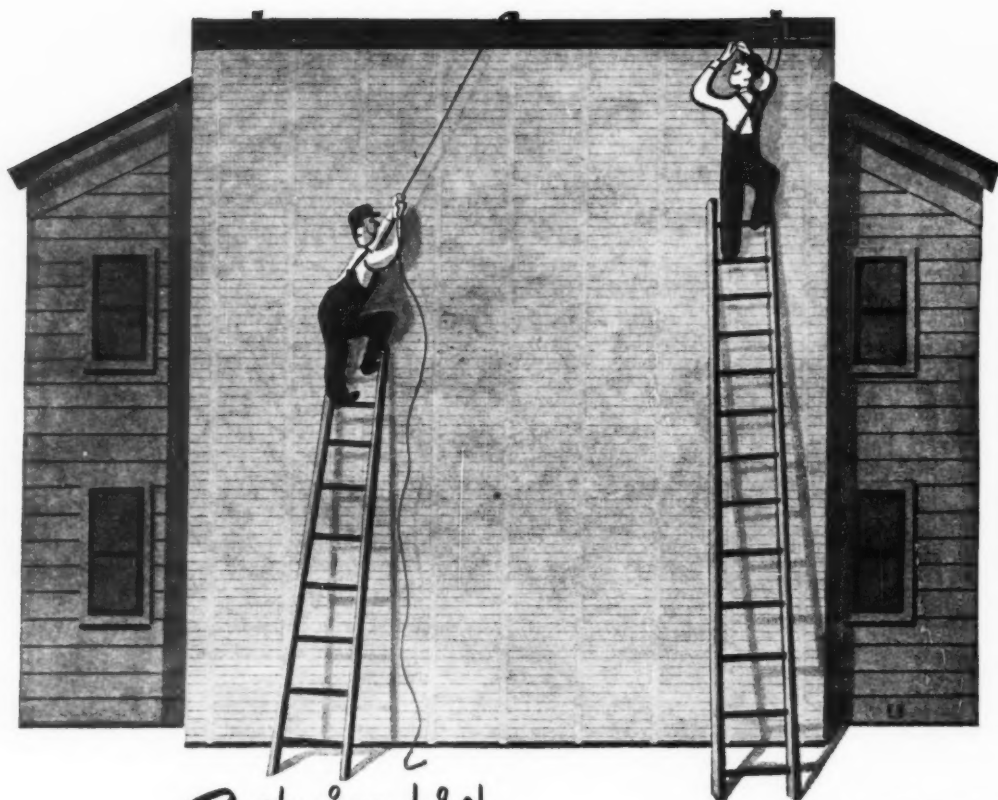


More and more, Micarta is being used for furniture tops in hospitals and institutions. Micarta Truwood, made with genuine wood veneers, is widely used for such applications. Incidentally, Micarta can be worked by hand tools. It can be sawed, trimmed, planed and drilled.

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dependable operation on any scale. "CCC" - Columbia - Controlled - Construction assures long wear and economy. Columbia styling assures smart looks.

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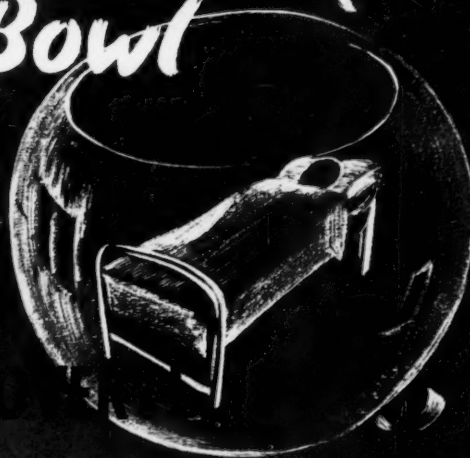
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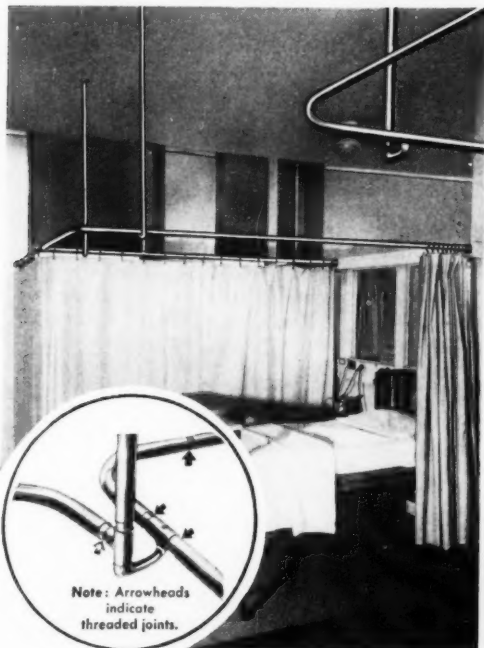
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NEWS...

Florida A. and M. College Starts Construction of \$2,000,000 Health Center

TALLAHASSEE, FLA.—Construction of a \$2,000,000 hospital health center and nursing school building was undertaken here last month at the Florida Agricultural and Mechanical College. The building was described by college officials as "the most expensive building ever constructed on a Negro college campus in the country."

Speakers at the formal ground break-

ing ceremony, February 9, described the project as "an example of democracy and interracial good will in action." Funds for the building were raised by both public and private financing, it was explained, with various political and racial groups participating.

Completion of the medical service center will mark a great milestone in providing the medical and nursing facilities "so urgently needed by Negroes in the South," Dr. William H. Gray Jr., president of the college, declared. "This

example of interracial neighborliness is a great joy to all of us here today," Dr. Gray said.

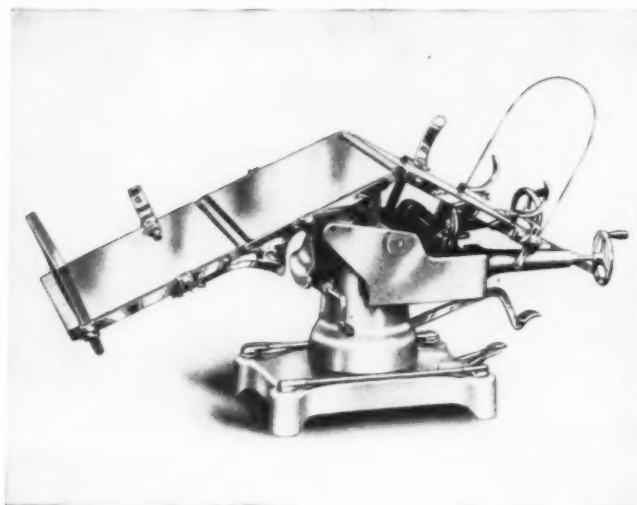
The new building will include facilities for a 100 bed hospital, a nursing school which will admit 100 student nurses, and teaching facilities to provide for clinical training of more than 100 physicians. Both white and Negro physicians will be on the medical staff, it was explained.

Suggests Revisions in Hospital Internship

NEW YORK.—Revision of the hospital internship to provide broader experience and better to equip the young physician to meet the personality, social and community problems which he will face in practice was proposed here last month by Dr. Benjamin P. Watson, president of the New York Academy of Medicine, in his inaugural address.

Dr. Watson suggested that desirable added experience might be obtained by an exchange in personnel between large teaching hospitals in cities and smaller community hospitals, or by a modification of the old apprenticeship system under which the intern would be associated with members of the staff in private practice while carrying on his hospital work as an extern.

Dr. Watson also stated that reforms were needed in medical education to intensify undergraduate collegiate training so that the medical program might be completed at an earlier age.



New! Hermann Operating Table by Champagne!

The Hermann Major Operating Table, S-1506, is the result of careful surgical research and Champagne engineering skill—combined to provide unique features not available on any other table.

- **EXTREME KIDNEY POSITION** of 130° at minimum 32" height eliminates need of kidney elevator and footstool—provides complete body support to extremities.
- **SINGLE CONTROL ADJUSTMENT** from kidney to reflex abdominal positions facilitates closure of body opening for suturing.
- **LOW 90° CHAIR POSITION** at 26" minimum height—ideal for brain and EENT surgery.
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The above and other outstanding features of the new **Hermann Major Operating Table** justify immediate investigation.

Sold through Surgical and Hospital Supply Dealers.

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Mount Sinai Adds Two Laboratories and Pavilion

NEW YORK.—Addition of a ten-story maternity pavilion and two research laboratories to the facilities of Mount Sinai Hospital was announced here last month. The expansion program will cost \$7,000,000, it was estimated. Construction has been undertaken according to Alfred L. Rose, president of the hospital. Funds raised by the hospital to finance the project are augmented by contributions from the Federation of Jewish Philanthropies of New York, Mr. Rose said.

The maternity building will have 160 beds for ward, semiprivate and private patients, as well as an institute of biogenetics for education and research programs. An additional building will house present hospital laboratories and a new laboratory department, it was explained.



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I'll show you how to stain it! Send my
FREE sample of Varlar and I'll make my
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NEWS...

International Hospital Federation to Meet in Amsterdam, May 30-June 4

CHICAGO.—The International Hospital Federation will meet in Amsterdam, Holland, May 30 to June 4, it was announced at American Hospital Association headquarters here last month. Donald C. Smelzer, M.D., chairman of the association's council on international relations, will be the official American delegate. An invitation has been extended to all hospital people in the United States and Canada to attend.

An independent study organization, the International Hospital Federation aims at maintaining an exchange of hospital information and experience among hospital associations and other public and private institutions, organizations and individuals interested in hospital work, the announcement said. Its activities include the collection of all national literature on hospital work and practice, conferences and building plans; organization of study tours and study courses in hospital work; setting up of international study committees and publication of their reports; promotion of national hospital organizations in countries where there are none, and publication of an international hospital journal.

A member of the World Health Organization, the federation includes the American Hospital Association and hospital associations of Belgium, Denmark, France, Great Britain, Holland, Ireland, Italy, Luxembourg, Norway, Sweden and Switzerland. Successor to the International Hospital Association, the federation was organized in 1947.

Name Carolina Officers

GREENVILLE, S.C.—James L. Rogers, administrator of the Spartanburg General Hospital, Spartanburg, S.C., was named president-elect of the South Carolina Hospital Association at the annual meeting of the association here last month.

Other officers named were: vice presidents, T. B. Stevenson, Colleton County Hospital, Walterboro; Rev. W. M. Whiteside, South Carolina Baptist Hospital, Columbia; vice president, Sister Bernadette, St. Eugene Hospital, Dillon; trustees, F. O. Bates, Roper Hospital, Charleston; James M. Daniel, Columbia Hospital, Columbia, and secretary-treasurer, Allen D. Howland, South Carolina Hospital Service Plan, Greenville.

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A light touch operates all keys on the

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NEWS...

Proposed N.J. Medical Center to Be Included in N.Y.U.-Bellevue Regional Plan

NEW YORK.—Partnership between a rural medical center and a metropolitan, university-affiliated center is contemplated under inclusion of the proposed Hunterdon County, New Jersey, medical center as a member of the New York University-Bellevue Medical Center's regional hospital plan. The affiliation was announced last month by Winthrop Rockefeller, chairman of the New York

University-Bellevue Medical Center board, and Clifford Snyder, president of the proposed rural center.

Hunterdon County is the only county in the state which does not have a hospital of its own, it was pointed out. With its population of 38,000 now receiving medical care from only thirty-two practicing physicians, the new Hunterdon Medical Center will provide a 125 bed hospital and affiliated health facilities designed to provide first-rate, modern medical care. Funds for the new project are

to be raised primarily in the county, with the federal government expected to contribute through the Hill-Burton Act.

Following an extensive survey of the health and hospital needs in Hunterdon County, Dr. E. H. L. Corwin, executive secretary of the New York Academy of Medicine, commented on the affiliation as one which will make the Hunterdon Hospital "a forerunner of the type of organization which rural hospitals may want to follow in other parts of the country, and one which will bring to this rural area a number of young doctors of the highest caliber."

Outlining the plan, Dr. Corwin said that it strengthens the position of the county's medical profession and makes available to its doctors a consulting service and an opportunity to extend the field of their usefulness to the patient. "The affiliation," he said, "will serve as an attraction, not only to the patients who desire superior medical care near home without having to go to the large urban medical centers, but also to physicians to settle in the county in the future." He stated that the affiliation of the Hunterdon County Medical Center with New York University should assure it immediate recognition from the American Medical Association for the training of interns and residents.

Administered under the regional hospital plan, a teaching program for rural and suburban hospitals financed by the Kellogg Foundation, the Hunterdon affiliation will include provision for a member of the teaching staff of New York University-Bellevue to sit on the medical board of the Hunterdon center. Chiefs of services of the Hunterdon Hospital will have academic rank on the university faculty, and faculty specialists in New York can be called on for consultation in particularly difficult cases. Also, senior undergraduate medical students will spend time at Hunterdon Hospital to become acquainted with the nature of rural medicine. Resident doctors from the University Hospital and Hunterdon Hospital will rotate. In addition, a new Hunterdon school of nursing will be affiliated with the Bellevue school of nursing and trainees will spend part of their training period at the Medical Center.

Other hospitals included in the plan are: Easton Hospital, Easton, Pa.; Fitkin Memorial Hospital, Neptune, N.J.; Flushing Hospital, Flushing, N.Y.; Grasslands Hospital, Valhalla, N.Y.; Meadowbrook Hospital, Hempstead, N.Y.; Monmouth



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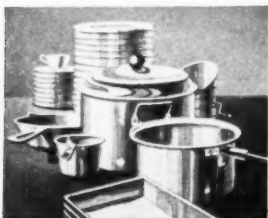
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Economical
Pleasant odor**



For disinfecting floors, walls, furniture, bedding. Won't fade or discolor.



For the disinfection of surgical instruments and rubber goods.



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Freight prepaid on 10 or more gallons shipped at one time to one address. Terms 2/10 days, 30 days net.

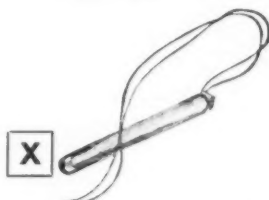
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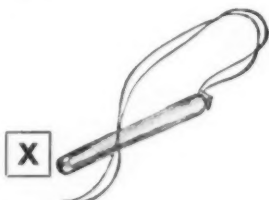
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BETTER THAN CULTURES

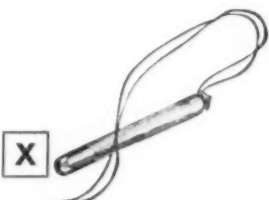
—Diack Controls provide a better check on sterility of your autoclaved goods than cultures.



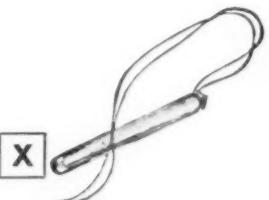
Safer—*B. subtilis* is destroyed far below melting conditions required for Diacks.



Time saving—a wait of one to ten days incubation with cultures. No wait with Diacks.



Economical—cultures are costly in time consumed alone. Diack's cost is comparatively lower.



Checks Autoclave before next load—you may under-sterilize several loads before previous culture indicates a faulty autoclave. An unmelted Diack will check it before the next load.

Diack Controls

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NEWS...

Memorial Hospital, Long Branch, N.J.; New Rochelle Hospital, New Rochelle, N.Y.; North Country Community Hospital, Glen Cove, N.Y., and St. Luke's Hospital, Newburgh, N.Y.

D.C. to Pay for Care of Medically Indigent

WASHINGTON, D.C.—The District of Columbia was authorized to pay voluntary hospitals for care of medically indigent patients "even though such patients can pay part of their own hospital bills," according to a ruling made here last month by the District commission. Heretofore, the District has paid hospitals only for treating patients considered so destitute that they could pay nothing toward their own expense, it was explained.

Under a table of family income limits, eligibility for District aid will be determined according to ability to pay. Persons whose income falls between the minimum and maximum limits stated in the table are considered indigent as far as payment for full medical care is concerned but may be able to pay part of the costs.

The income limitation table, adopted by the District two years ago to govern payments for care at Gallinger Hospital, is as follows:

Number of Persons Supported by Family Income	Gross Monthly Income	
	Minimum	Maximum
1	\$100	\$200
2	110	210
3	120	220
4	150	250
5	175	275
6	190	295
7	200	300
8	210	310
9	220	320
10	230	330

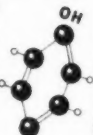
Break Ground for New Hospital

MORRISTOWN, N.J. — Ground was broken here last month for the new Morristown Memorial Hospital, which will provide a substantial increase in bed capacity, it was reported by hospital officials. The plans for the new hospital will enable the institution to handle with maximum ease peak demands for private, semiprivate or ward accommodations, the report said. Ready expandability is brought about through initial construction of ample service facilities and definitely earmarking added bed space within the outer limits of the new building.

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first PHENOL

Popularly called carbolic acid, phenol is a powerful caustic poison with disinfecting qualities. It is toxic and has the characteristic phenolic odor.



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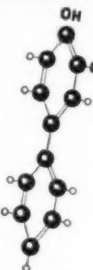


Derived from phenol, cresol is less caustic and toxic. It has a strong-smelling odor in use.

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ARO-BROM^{G.S.} The Modern, Non-Specific GERMICIDE

ARO-BROM G.S. is the ideal odorless, non-corrosive and non-toxic disinfectant—no radical departure from the universally accepted principles of older disinfectants. Extremely effective and completely safe in use, ARO-BROM has been tried, tested and approved in America's hospitals. Non-specific with excellent penetration characteristics, ARO-BROM is truly economical for general disinfectant use in the hospital. Write for full details.



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Assure FULLEST MEASURE
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The Ultimate in
Richness, Elegance and
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MODEL T-20-AS
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Height 26"; 10" Square
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with Leakproof, Hot-Dipped Galvanized Pail
Height 26", 10" Square, 20 Quart Capacity

*All Models Available in
White Enamel, Cream
White, Grained Mahog-
any or Walnut ... or any
special color.*



You may expect extraordinary long life and dependable trouble-free performance from these brilliant new Sanettes. Only the finest quality stainless steel is used, — corrosion resistant and highly polished for easy cleaning and continued bright lustre.

Designed with smoothly rounded continuous corners . . . no crevices for dirt to collect. The leakproof inner pail in all closed-top models is round for ease in cleaning; space between pail and outer container is completely closed.



Your dealer can supply all sizes, — from 12 to 30 quart capacities. Illustrated folder S-327 sent on request.

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NEWS...

New York Blue Cross Plan Increases Subscriber Rates to Meet Rising Costs

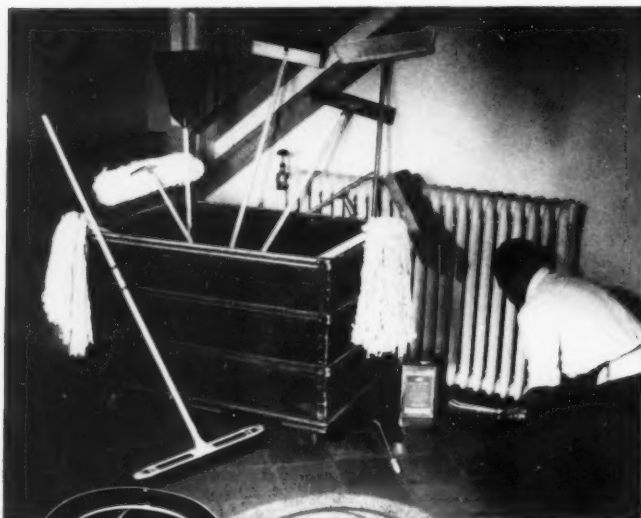
NEW YORK.—An increase in the subscription charges of Associated Hospital Service, New York's Blue Cross plan, to meet increased hospital costs was announced last month by Louis H. Pink, president. The new charges became effective immediately for new members; those already enrolled will be required to pay the new rates May 1 or on the date of their next regular payment after May 1.

The new monthly rates for group membership are \$1.24 for an individual, \$2.72 for a husband and wife, and \$3.56 for a family as compared with the present rates of \$1, \$2.20 and \$2.72, respectively. New rates for nongroup membership, payable on a quarterly basis, are \$4.50, \$9.45 and \$12.15 as compared with present rates of \$3.60, \$7.50 and \$9.30.

The increased rates were approved by the New York State Insurance Department after a review of the financial

structure of Associated Hospital Service and increased hospital payments.

"Two years ago, when an increase was put into effect," Mr. Pink said, "we hoped that the inflationary period was over. During the last two years, however, hospital costs and charges have continued to rise and have gone up approximately 35 per cent. Since Associated Hospital Service members constitute more than one-third of all hospital patients, we have to make our payments sufficiently adequate not only to keep the hospitals going but to permit a high standard of service. We have been able to defer this second rate increase only because of our strong financial position. If it were not for that, it would have been necessary to increase rates six months earlier. The new charges will enable us to continue to compensate hospitals fairly for their services and also to set aside the reserve funds required by the insurance department."



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Hospital Provides Television Service to Private Patients

NEW ROCHELLE, N.Y.—The New Rochelle Hospital here is providing television service to private patients, it was announced last month. Other hospitals in the New York metropolitan area were said to be considering the same step, according to newspaper reports.

Television sets were installed as an experiment but proved such a success with patients that the hospital intends to carry installations forward on a large scale, Alex E. Norton, superintendent of the hospital, reported.

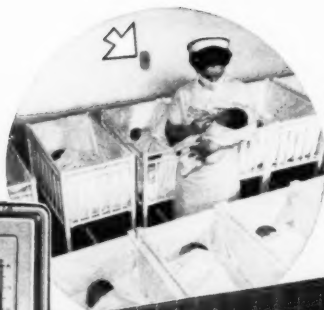
A number of hospital administrators have visited New Rochelle to inspect the installations, he said.

Hospitals in Chicago and other metropolitan areas served by television broadcasts have also installed receiving equipment, it was reported.

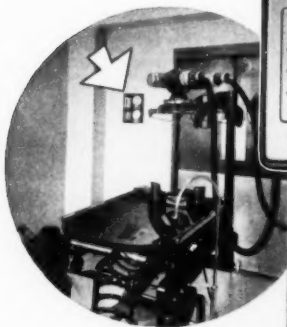
Council Elects Officers

KANSAS CITY, KAN.—Bruce W. Dickson, administrator of Bethany Hospital, Kansas City, Kan., was elected president of the Kansas City Area Hospital Council at the annual business meeting here recently. Other officers elected by the council were: vice presidents, C. Steacy Pickell, Kansas City health department, and Elizabeth Martin, Mercy Hospital; secretary, Henry J. Meiners, Cushing

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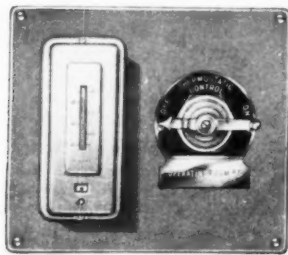
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Legge Safety Engineer: You're using a wax and it doesn't last. Your crew has to wash it off each time . . . then put on a new coat. They go through the same rigamarole every week. It takes a lot of time.

Mr. Higby: What can be done?

Legge Safety Engineer: Use a Legge Non-Slip floor polish. It stands up under heavy traffic. I'll show your crews how to make it last by cleaning and buffing . . . sometimes mopping on more polish. But they won't have to strip it off. That's the work that takes time.

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Legge Safety Engineer: They'll stay that way if your men follow my instructions. I'll stop by often to make sure they do.



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He's the Legge Safety Engineer who has helped Mr. Higby in your area get well-kept floors at lower cost . . . reduce slippery-floor accidents up to 95%. He engineers an upkeep program to your floors; instructs your maintenance crews in efficient Legge System methods. His advice is free; his supervision is part of your purchase of Legge Non-Slip floor-care products.

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NEWS...

Hospital, Leavenworth; treasurer, Sister Agnes Cecelia, Providence Hospital; executive committee members, Dr. David Littauer, Menorah Hospital, and Sister Margaret, St. Joseph Hospital.

\$1,500,000 Gift Made to Sloan Foundation

NEW YORK.—A gift of \$1,500,000 to the Alfred P. Sloan Foundation was announced here last month as a tribute to Alfred P. Sloan Jr. from 10,000 automobile dealers throughout the country. The gift will be used for cancer research at the foundation's Sloan-Kettering Institute for Cancer Research, it was reported.

The gift was presented by General Motors dealers in appreciation of Mr. Sloan's cooperation in improving automobile distribution, a spokesman for the group said. In accepting the gift on behalf of the foundation, Mr. Sloan said, "This demonstrates that there is something in business besides business."

Starts Practical Nurse Program

BERKELEY, CALIF.—A training program for practical nurses has been established at the Herrick Memorial Hospital here and is approved by the Association of California Hospitals, Alfred E. Maffly, administrator, announced recently. The course includes instruction in practical nursing procedures, sickroom housekeeping, hygiene, cooking for the sick, and related subjects, Mr. Maffly said. Graduates will receive certificates from the hospital and may then be employed as practical nurses throughout the state, it was explained.

Delaware Hospitals Ask State Funds

WILMINGTON, DEL.—The Association of Delaware Hospitals will ask the state to provide \$573,000 a year for maintenance, equipment and operation of hospitals under a bill proposed by members of the association's legislative committee. Additional legislation will be requested seeking a substantial increase in the daily rate now paid hospitals for care of indigent patients. Dr. A. J. Hockett, administrator of the Wilmington General Hospital, is chairman of the committee.



KOHLER SERVICE SINK

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Kohler quality, a 76-year-old tradition, includes such features as glass-hard, long wear-

ing surfaces that are non-absorbent and easy to keep clean; chromium plated brass fittings that are precision made and carefully tested for performance; designs that embody recommendations by leading surgeons and conform to the plumbing codes of all states.

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"But it's not only that the job is easier. It's a real satisfaction to do a job *well*. And this machine does just that. Yessir! I'm sold on HILD. And I'm sold on my job now, too."



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NEWS...

State Associations Don't Know Own Strength, Speaker Says

(Continued From Page 134.)

the Philadelphia Hospital Council warned hospital people against the type of thinking that regards federal compulsory health insurance as inevitable. This is a wrong attitude, Dr. Rorem said; instead, hospitals, Blue Cross and Blue Shield groups should work together unselfishly and energetically to see that adequate health services are provided at reasonable cost for all the people by voluntary means.

Reporting on a recent conference with U.A.W.-C.I.O. health representative Harry Becker, Dr. Dwight Barnett of Detroit said the union group will not demand the compulsory government plan if full health services are available through Blue Cross and Blue Shield. Furthermore, Dr. Barnett said, the union would favor government aid administered through state rather than federal agencies. The administration may give up its plan to attempt passage of a full health service bill in the present Congress, Dr. Barnett said, and substitute a bill providing compulsory hospitalization insurance only. Many union officials believe that medical care features of the insurance provision must be omitted in the initial stages, he said.

Speaking at a dinner meeting of the conference, Dr. Melchior Palyi, Chicago economist, described the historical development of social security programs in Europe and warned that socialized medicine in this country would lead eventually to bankruptcy of the government. He elaborated on the administrative complexities that are inevitable under a government medical plan.

Speaking informally for the Blue Cross Commission, Richard M. Jones, director, told the conference how the newly incorporated national Blue Cross health service was progressing in its organizational phases and how the program would work to provide uniform hospitalization benefits nationwide.

A number of the state association officials attending the conference expressed the opinion that the A.H.A.'s national public relations program, which was recently given up because of lack of interest on the part of member institutions, should be revived and strongly prosecuted. On an informal vote, the conference strongly approved resumption of the effort to raise the necessary funds and go forward with the

public relations campaign. It was decided that state hospital associations should assume responsibility for interesting member hospitals in the program and obtaining the necessary contributions for its financing.

Fred A. McNamara, chairman of the association's council on association relations, emphasized the valuable contributions that could be made to the association by federal hospitals. Mr. McNamara urged the development of a single hospital system that would embrace federal, state and local government hospitals as well as voluntary institutions in an integrated program of caring for the sick.

In the closing discussion of the conference, E. W. Jones, vice president of The Modern Hospital Publishing Company, Inc., said that Blue Cross and hospital people should work together to get the federal reimbursable cost formula for payments to hospitals adopted by all federal, state and local government agencies. If the problem of payment to hospitals for indigent patients can be solved, Mr. Jones said, then hospitals can lower the rates charged to private and semiprivate patients, with resulting improvement in relations with Blue Cross plans and other financial aspects of hospital operation.

Announces Expansion Plan

WILMINGTON, DEL.—A \$700,000 expansion program was announced by the Wilmington General Hospital here last month. Plans include construction of a \$200,000 kitchen and laboratory unit and a wing estimated to cost \$500,000. The kitchen and laboratory program will be financed by contributions already made to the hospital's building fund, Cole Coolidge, president of the board of directors, said. Additional funds will be required for the new wing, he added.

Begin Hospital Construction

NELSONVILLE, OHIO.—Construction was undertaken here last month on a \$1,250,000 hospital for the Sisters of St. Francis of Penance and Christian Charity. The project, known as the Mount St. Mary Hospital, will have seventy-five beds and additional public health facilities to serve residents of three counties in the Nelsonville area, it was reported. The modern institution will be completed and ready for operation early in 1950, the report said.



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SCHEDULED AIRLINES OF THE U. S.

NEWS...

West Side Medical Center Announces Five-Year Plan

CHICAGO.—The West Side Medical Center here will have \$50,000,000 worth of new hospitals, schools, research and allied medical institutions within the next five years, Dr. Walter H. Theobald, president of the medical center commission, stated in the commission's annual report last month. The present medical center plant is valued at \$100,000,000 today, the commission report stated.

Expansion plans include a 500 bed general medical and surgical hospital to be built by the Veterans Administration, additions to the medical and nursing schools' facilities of the University of Illinois, improvements and additions to the Cook County Hospital, construction of a state tuberculosis hospital and institution for tuberculosis research, expansion of hospital and nursing school facilities of the Presbyterian Hospital, enlargement of Loyola University Medical School plant, construction of a building for the Chicago Medical Society and replacement of the building now occupied by the Cook County Graduate School of Medicine.

These projects will be undertaken within the next five years, according to Dr. Theobald's report.

Complete Second Addition to Arthritis Sanatorium

OTTAWA, ILL.—The second major addition in the last three years to the Ottawa Arthritis Sanatorium and Diagnostic Clinic here has recently been completed, it was announced last month. The newly completed addition will make available twenty-six more beds and facilities for fifty more outpatients weekly. Established in 1933, the sanatorium completed its first addition in 1946. At that time, a new laboratory, employees' dining room, business office, and staff offices were constructed. The latest addition includes private and semiprivate rooms and three and six-bed sun parlors.

The addition is heated by a ceiling type of radiant heating system, it was explained. This is believed to be the first heating system of this kind to be placed in a hospital anywhere in the country. The system affords uniform temperature throughout the building the entire year without the necessity of radiators, registers or steam pipes.

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You just how many servings, swell,
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The best of fruits and berries fine
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That's why these products taste so grand.
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NEWS...

4000 New York Patients Tested for Tuberculosis

NEW YORK.—More than 4000 patients admitted to Morrisania City Hospital wards since last May have been x-rayed under a project sponsored jointly by the City Department of Hospitals and the Bronx Tuberculosis and Health Committee. Dr. Nathan Smith, medical superintendent of the hospital, reported recently.

Dr. Eli Rubin, director of the project, found in a study of the first 2000 cases

that about eight times as many active tuberculous patients were found as occur ordinarily in examining community groups. A large proportion of these cases were previously unknown. Patients with active tuberculosis are isolated to protect other patients and the hospital staff from infection, it was explained. This project has had the further value of giving the medical students, interns and residents in the hospital a wide experience and of making them tuberculosis conscious, Dr. Rubin said.

Start Construction of Heart Hospital in Minneapolis

MINNEAPOLIS.—Construction of the \$1,000,000 Variety Club Heart Hospital at the University of Minnesota here has been undertaken following the approval of funds allocated by the U.S. Public Health Service under Public Law 725 and awarding of construction contracts, according to a university announcement. The new eighty-bed hospital will be erected on the Mississippi River bank adjacent to the present university hospitals, it was explained.

Completed, the new hospital, with equipment, is expected to cost \$987,285. Funds which will pay for the structure will come from the following sources: Variety Club of the Northwest, the federal grant, university funds now on hand, and a bank loan of \$100,000 to be repaid over a ten-year period, the university stated.

Senate to Study Health Program

WASHINGTON, D.C. — The Senate committee on labor and public welfare is expected to take up the health insurance question after it has acted on amendments or a substitute for the Taft-Hartley labor law. Senator Robert Taft of Ohio told newspaper reporters last month. Senator Taft said he would submit a proposal for legislation providing for federal aid to states for care of indigent patients and financing voluntary health insurance.

Republican leaders here were said to be solidly behind the move to block passage of legislation favored by President Truman and Federal Security Administrator Oscar Ewing.

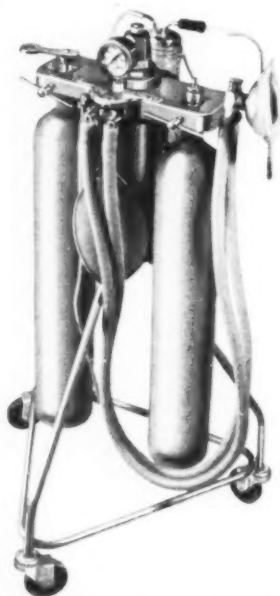
Cleveland Nurses Offered Lectures in Counseling

CLEVELAND.—A series of monthly lecture-discussions on "Counseling and Guidance Programs in Schools of Nursing," has been started here under the sponsorship of the Frances Payne Bolton School of Nursing. Prominent national counselors will present lectures on the following subjects: preadmissions counseling and guidance, counseling techniques, the relation of the health service to the general counseling program for nurses, the rôle of the teacher, student counseling, vocational counseling

For that first breath of life you can rely ON AN EMERSON RESUSCITATOR

A rhythmic alternation of gentle pressure and suction has been found absolutely safe and maximally effective in the studies of Ivy, Schwerma, Thompson, Birnbaum, Martinez, Coryllos, and others.

A single lever control averts the danger of confusion in emergencies.



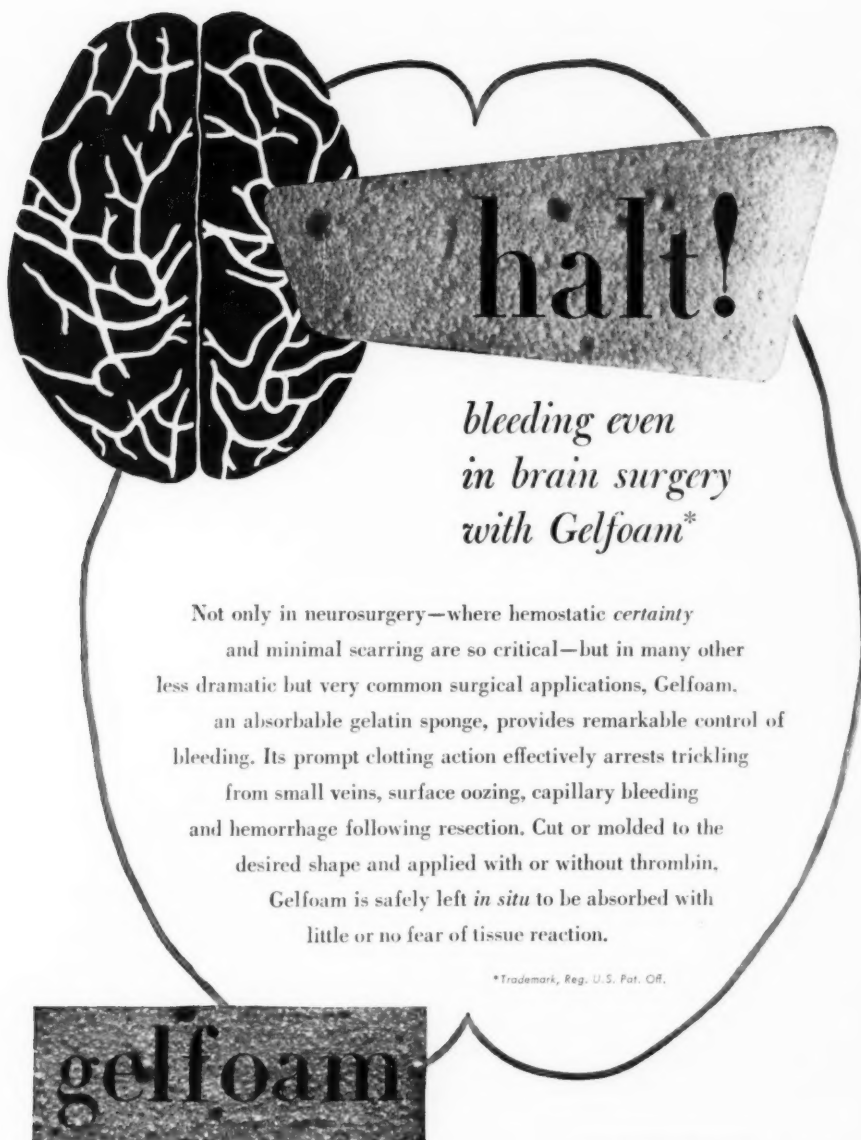
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*Trademark, Reg. U.S. Pat. Off.

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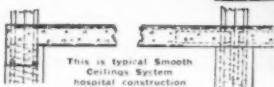
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Modern overhang design used in present day hospital construction is made easier and less costly with the Smooth Ceilings System.

The special steel grillages employed in this system are embedded in the concrete slab and may be used with reinforced concrete, cast iron, structural steel or steel pipe column.

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economical to use flat slab design in buildings for human occupancy. Eliminates waste space . . . reduces ceiling height . . . lowers cost of installing air conditioning ducts, piping, and electrical conduits . . . makes ceiling hung equipment easier to install . . . greatly reduces cost of concrete form work.

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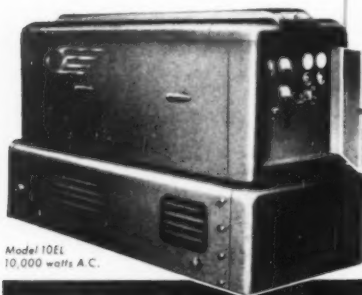
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Within seconds after power fails, Onan Standby Electric Plants take over the power load, providing electricity for all essential uses. Plants start automatically, activated by any break in electrical service, run for the duration of the emergency, stop automatically when regular power is restored. Require little maintenance between running periods. Shipped complete, ready to install and operate.



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10,000 watts A.C.

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ONAN Electric Plants are available in many models and sizes: A.C.—350 to 35,000 watts, D.C.—400 to 15,000 watts, Battery Chargers—500 to 6,000 watts.

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NEWS...

and placement, and planning a counseling and guidance program for schools of nursing.

The series was made possible through a grant from the W. K. Kellogg Foundation and was in response to a great interest expressed on the part of Western Reserve University graduate nurse students and the faculty of schools of nursing in this area.

Improve Relations With the Press, Editor Tells M.D.'s

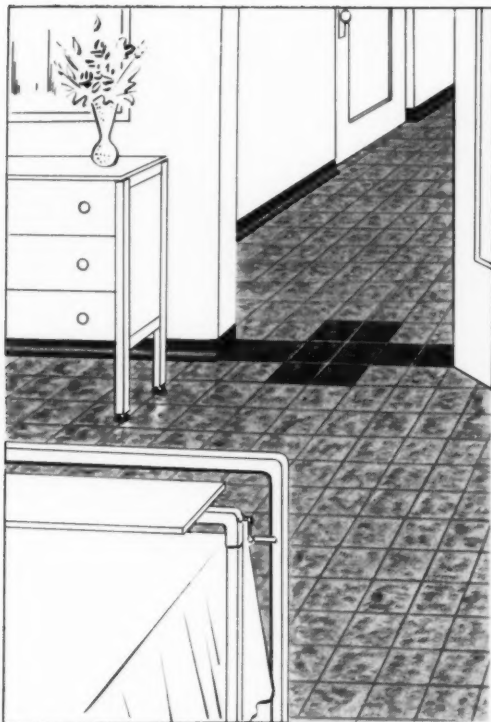
BOSTON.—Speaking at a meeting here of the Council of the New England State Medical Societies, Gerald E. McLaughlin, managing editor of the Rutland, Vt., *Herald*, pointed out that doctors and reporters would be saved a great deal of trouble if physicians would make it routine procedure to give pertinent information to the hospital information desk on accident cases.

As a rule, doctors have poor relations with the press, Mr. McLaughlin said. He cited results of an appraisal given him by managing editors of a number of papers. "Their answers," he said, "indicate that the generally poor press of the medical profession is due to a lack of understanding by doctors of the fundamentals of good public relations.

"In general, newspapermen find doctors unwilling to cooperate with them in the coverage of basic news stories. I refer to stories of accidents, violence, prominent deaths and illnesses. I think this lack of cooperation comes as a result of failure by both the doctors and the newspapermen to understand each other's problems.

"If a man is hurt or hospitalized as a result of an automobile accident, for instance, it is a matter of public record through routine police investigation. Therefore, it can be argued, the follow-through concerning his condition and the extent of his injuries is also public property. This is the view of one editor who wrote to me.

"In the case of serious illness of prominent men, the doctor can save himself trouble, the family embarrassment and the city desk acute discomfort, if bulletins on the patient are issued regularly. Newspapermen can understand the doctor's responsibility, but if the ill person is someone of public prominence, his illness is a matter of concern to people outside the family."



"Asphalt tile takes hard use best!"

"Our asphalt tile floors get plenty of hard use. From morning to night, seven days a week there's a continual flow of foot traffic plus rolling equipment over our corridor floors. And they prove they can take it."

"But the hardest use is in our service areas. In the laundry, for instance, our Armstrong's Asphalt Tile Floor gets plenty of scuffing from heavy clothes hampers and is also subject to strong alkaline soap solutions. But to look at this floor, you wouldn't think that it was installed over ten years ago—it's so colorful and new looking."

"Yes, I looked over a lot of floors, too. But I found that Armstrong's Asphalt Tile had good looks and everything else I wanted in a serviceable floor. And its cost was low, too."



"Linoleum takes hard use best!"

"Don't think this linoleum floor of ours has an easy time of it. We have service traffic, of course, and people seem to come in droves during visiting hours. Even where the floor gets the most use—around the reception desk and elevators—there's little sign of wear."

"Lots of other things sold me on Armstrong's Linoleum, too—like the fact that it's such a quiet floor and easy on your feet. It's got a smooth surface that makes it a cinch to keep clean. Wash and wax it occasionally and it stays just as bright as you see it."

"We've remodeled twice since we opened in 1923... used Armstrong's Linoleum both times. We don't think it can be beat."

WE MAKE BOTH FLOORS, so we should be able to settle this argument. But it isn't easy to do. Under certain conditions, Armstrong's Linoleum will stand up better. In other cases, Armstrong's Asphalt Tile will give a better performance. Both floors are equally easy to clean. You must consider your specific needs in choosing one floor against the other.

Armstrong's Asphalt Tile usually costs a little less—and its tile form permits unusual freedom in designing. However, Armstrong's Linoleum is often preferred for rich custom-floor styling. Linoleum is quieter underfoot and takes heavier loads without indenting. If your subfloor is concrete in contact with the ground, asphalt tile is necessary to withstand the effects of alkaline moisture. Where grease and oil may drop on the floor, use Armstrong's Greaseproof Asphalt Tile.

To help you decide which floor is better for your needs, here's what we suggest: **Drop us a card and we'll send you two booklets**—one about Armstrong's Linoleum, another about our Asphalt Tile. To compare samples or actual floors in your locality, see your Armstrong flooring contractor. Write Armstrong Cork Company, Floor Division, 5703 State Street, Lancaster, Pennsylvania.



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NEWS...

Issues New Directory of Medical Specialists

CHICAGO.—A complete roster of the nation's 27,000 certified medical specialists is available in the new directory of medical specialists published this week by the A. N. Marquis Company of Chicago, publishers of "Who's Who in America." Now in its fourth edition, the directory of specialists is compiled for the Advisory Board of Medical Specialists, representing the sixteen specialty

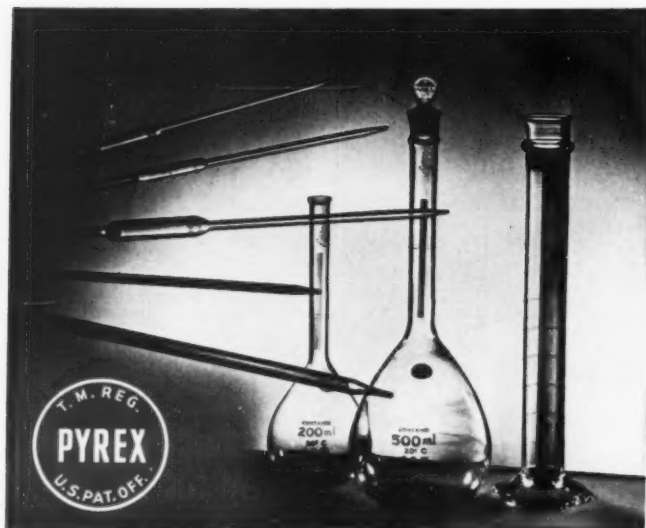
boards in the various branches of medicine.

Used extensively by hospitals, medical schools and societies, government offices, insurance companies, newspapers and other organizations, the directory is also on the shelves of many public libraries throughout the country. In addition to individual listings giving the details of each specialist's training, including internships, residencies and fellowships, and showing his teaching and hospital staff positions, medical society member-

ships, and other professional qualifications, the 1150 page directory also presents full information about the requirements leading to certification by the various specialty boards.

A new feature appearing for the first time with this edition is a latest-listings supplement, now on the press, which will be distributed without cost to all directory subscribers. This adjunct service presents biographical and professional data on more than 1000 specialists whose certification had not been completed or whose biographies were not on hand at the time the directory itself was closed, the publisher explained.

Dr. Edward L. Jenkinson of Chicago, chief radiologist at St. Luke's Hospital there and associate professor of radiology at Northwestern University Medical School, is chairman of the directory committee for the Advisory Board of Medical Specialists. Members of the editorial advisory board are: Dr. S. Judd Beach (ophthalmology), Cape Cottage, Me.; Dr. Dean M. Lierle (otolaryngology), Iowa City, Iowa; Dr. Paul Titus (obstetrics and gynecology), Pittsburgh; Dr. George M. Lewis (dermatology and syphilology, New York City; Dr. Lee E. Hill (pediatrics), Des Moines, Iowa; Dr. Francis J. Braceland (psychiatry and neurology), Rochester, Minn.; Dr. B. R. Kirklin (radiology), Rochester, Minn.; Dr. Francis M. McKeever (orthopedic surgery), Los Angeles; Dr. Harry Culver (urology), Chicago; Dr. William A. Werrell (internal medicine), Madison, Wis.; Dr. Robert A. Moore (pathology), St. Louis; Dr. J. Steward Rodman (surgery), Philadelphia; Dr. Paul M. Wood (anesthesiology), New York City; Dr. Louis T. Byars (plastic surgery), St. Louis; Dr. William J. German (neurological surgery), New Haven, Conn.; Dr. Robert L. Bennett (physical medicine), Chicago.



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CORRECTION

Lloyd C. French, former administrator of the Knickerbocker Hospital in New York City and author of the article "Alcoholic Ward Poses No Special Problem," which appeared in The MODERN HOSPITAL for January 1949, was incorrectly identified as a physician in connection with publication of the article. Mr. French is now administrator of the Mesa Hospital, Mesa, Ariz.



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**BETTER THINGS FOR BETTER LIVING
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ABOUT PEOPLE

(Continued From Page 90.)

Albert H. Scheidt has been appointed administrator of the Dallas City-County hospital system in Dallas, Tex., which includes the Parkland Hospital, the



A. H. Scheidt

Woodlawn Tuberculosis Hospital and a 135 bed convalescent hospital. The system comprises a total of 650 beds. Mr. Scheidt has served for the last two years as administrator of the Foundation Hospital at New Orleans. Prior to his service as a member of the medical administrative corps of the U.S. Army he was administrator of the Miami Valley Hospital at Dayton, Ohio, and earlier, assistant director of Michael Reese Hospital, Chicago.

Dr. R. D. Thompson has been appointed medical director of La Vina Sanitarium, La Vina, Calif. He suc-

ceeds **Dr. Edward Kupka** who becomes director of the tuberculosis department of the California State Department of Health. Doctor Thompson was formerly superintendent and medical director of the Florida State Tuberculosis Sanatorium, Orlando.

Sister M. Justina, administrator of St. Joseph's Hospital, Alton, Ill., for six years, has been transferred to St. Mary's Hospital, Evansville, Ind. **Sister Helen** is the new administrator at St. Joseph's.

Arthur G. Burns has been appointed superintendent of Lawrence General Hospital, Lawrence, Mass. Mr. Burns has been associated for ten years with St. Luke's Hospital, New York City, having lately filled the post of second assistant director. He is a graduate of the course in hospital administration, School of Public Health, Columbia University.

Charles A. Turner has accepted the position of assistant to the administrator at Charles S. Wilson Memorial Hospital, Johnson City, N. Y.

Geneva Katz, R.N., has been appointed assistant director of the Boston Floating Hospital, a unit of the New England Medical Center. A graduate of the Boston University School of Education, Miss Katz was previously assistant administrator of Waltham Hospital, Waltham, Mass.

Lola I. Lindsey, R.N., has been named superintendent of Douglas County Hospital, Omaha, Neb. Miss Lindsey was director of nursing at the University of Iowa Hospitals School of Nursing, Iowa City, for more than twenty years.



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Department Heads

Helen Margaret McNeerney has been appointed director of the recently established Helene Fuld Student Health Service of the Hospital for Joint Diseases, New York City. A graduate of Mater Misericordia Hospital, Scranton, Pa., Miss McNeerney has had fifteen years' experience on the nursing staff at the Hospital of Joint Diseases.

Louise Carson has resigned as director of personnel at St. Luke's Hospital, Chicago.

Arthur C. Busch has been appointed to the newly created position of purchasing agent at Middlesex General Hospital, New Brunswick, N. J.

Evelyn Richardson is director of nurses at New Rochelle Hospital, New Rochelle, N. Y. Miss Richardson had been superintendent of nurses at Fordham



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Hospital for two years previous to her appointment at the New Rochelle Hospital.

Dr. Vincent J. Collins, consultant to the surgeon general, Army Medical Center, Fort Totten, N. Y., has been appointed to the post of chief of anesthesiology at St. Vincent's Hospital, New York City.

Frances Penfield has been appointed executive housekeeper, Overlook Hospital, Summit, N. J.

Dr. Marta Fraenkel has been made research assistant at Mount Sinai Hospital, Cleveland.

Miscellaneous

Ernest L. Bliss, former director of the Eye, Ear, Nose and Throat Hospital at New Orleans, has been appointed a staff consultant by James A. Hamilton and Associates, hospital consultants, of Minneapolis. Mr. Bliss is a graduate of the University of Chicago's course in hospital administration.

Dr. George Bachr, retiring president of the New York Academy of Medicine, has been elected chairman of the board of directors of the Health Insurance Plan of Greater New York.

Sheldon A. Miller has assumed his new position as medical administrator

of the Economic Cooperation Administration Mission to Greece, which is engaged in a construction program to rehabilitate war damaged hospitals and develop a well balanced system of hospitals, sanatoriums, laboratories and health centers, as well as to improve medical and nurse education. Mr. Miller received his master's degree in hospital administration from Northwestern University in June 1947.

Dr. Robert C. Darling recently was named to coordinate the physical medicine program at Columbia University.

Jack Mordell, formerly chief pharmacist at the University of Syracuse Hospital and School of Medicine, is now in the U.S. Public Health Service Hospital Division.

Ruth Adams is serving as deputy director of the Veterans Administration's nursing service in Washington, D. C., while **Matilda E. Dystra** is on leave of absence to attend classes at Columbia University. Miss Adams served with the army nurse corps in World War I. She is a graduate of Presbyterian Hospital School of Nursing, Philadelphia.

Deaths

Dr. Frederic M. Loomis, nationally known obstetrician and author, died last month at his home in Piedmont, Calif., following an illness of several months.

Dr. Loomis was 71 years old at the time of his death. He had been a member of the medical staff of the Peralta Hospital, Oakland, for many years and had also served the hospital as chairman of the staff and as a trustee.

Dr. Loomis was a medical student at the University of Michigan when the Spanish-American War broke out. He left school to serve in the army; after the war, he went to Alaska as a salesman, miner and editor of a mining paper. He stayed in Alaska for more than ten years, then returned to Ann Arbor and received his medical degree in 1912. He moved to Oakland a few years later and practiced obstetrics there for many years. Dr. Loomis was the author of several popular books and numerous articles in popular magazines. His first book, "Consultation Room," was a best seller in 1939 and has since been published in many foreign countries. One of his published stories, "Paid in Full," was being made into



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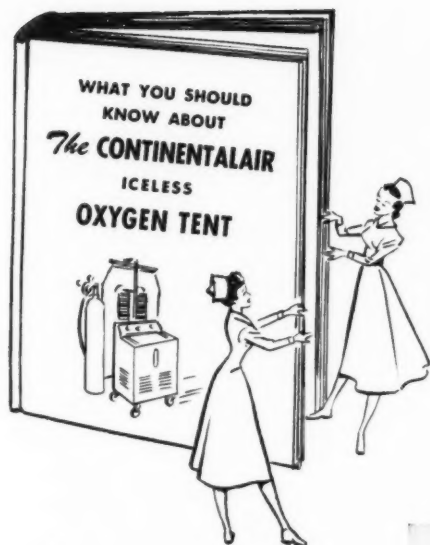
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a moving picture in Hollywood at the time of his death.

Dr. Loomis contributed an article to *The Modern Hospital* on the physician's view of hospital care which was published in October 1947 and was awarded honorable mention as one of the best articles published in this magazine during the year 1947-48.

Dr. Bertram B. Jaffa, former manager of health and charities in Denver, died recently at the age of 53 years. Dr. Jaffa served as executive secretary of the Colorado Hospital Association for twelve years.

THE BOOKSHELF

THE DEVELOPMENT OF SOUND PERSONNEL PRACTICES IN HOSPITALS.
A manual released by the Committee on Personnel Relations, Council on Administrative Practice of the American Hospital Association.

Recently, the committee on personnel relations under the Council on Adminis-

trative Practice of the American Hospital Association released the first of eight sections on hospital personnel administration entitled, "The Development of Sound Personnel Practices in Hospitals."

Clearly this manual is not the product of one man's thinking, nor is its approach to the complex problems of hospital personnel administration theoretical in nature. Rather, it is the result of intensive group thought, simply stated and logically supported.

It is pointed out in both the preface and the introduction to this manual that the committee is not recommending the standardization of personnel policies within our institutions, but that it is furnishing a guide for the intelligent development of a personnel program. Individuality among institutions, and co-operative development within institutions is the theme of this introductory section. The committee insists that the basic principles of sound personnel relations are applicable to all hospitals, but it is just as insistent that the specific policies should be adapted to the mores of the community and the hospital.

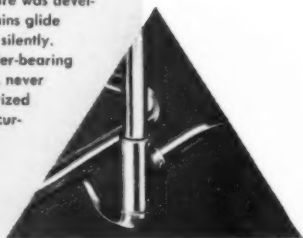
"Where policies are known at all levels and the administration has 'said what it means and means what it says,' there is little danger of misunderstanding." This is only one of many statements made in support of the need for written policies. It is pointed out that too often administrators expect sound interpretation of administrative thinking on the part of supervisors without having given them the guidance which could be made available to them through written policies.

The chapters covering the formulation, writing and distribution of personnel policies offer to all hospitals a definitive outline for the broadening of present policies, or for the development of a completely new program. Together with this comprehensive outline, a new philosophy is presented as an approach to personnel policy development. In the words of the committee, "The effectiveness of the hospital is dependent upon the best possible correlation of the objectives of the hospital with those of the employees who give the service specific meaning. It is the primary function of personnel policies to bring optimum

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correlation between the institutional objectives and the objectives of the employe group."

The committee places the administrator and personnel department in the position of interpreter and leader, recommending that first a general statement of policy, endorsed by the governing board, be obtained to include the objectives, services, lines of authority, and general attitude toward the employes. With these in mind, the administrator is then in a position to guide policy formulation through a representative committee of supervisors and em-

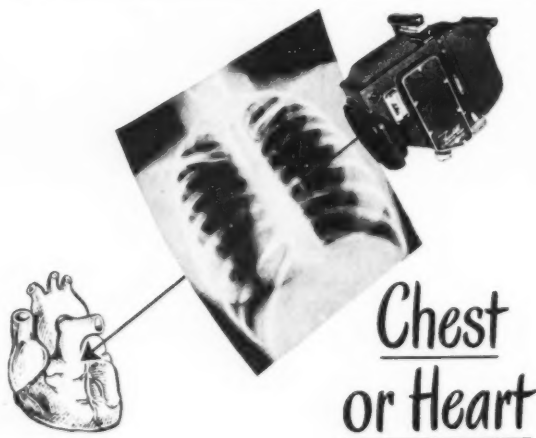
ployes. Committee development of policy is a long step from the usual procedure of adopting those already drawn up by other institutions. However, the justification and reasoning behind these recommendations are so strong as to leave little or no doubt as to the desirability of such a procedure.

In the appendixes to these manuals we are again cautioned to use the samples only to stimulate thought. Appendix A contains a selection of statements taken from personnel handbooks now in use. Appendix B is confined to statements covering specific details required

by supervisors to administer the general policies adequately. The last appendix is extremely interesting. Not only does it present a survey made in an actual hospital situation, but it shows the development of an outline based on the need presented by this survey. I feel confident that few administrators can read these few pages without being conscious of possible deficiencies in their institutions.

In addition to the manual under discussion, the committee on personnel relations has published a "Bibliography of Reference Material on Personnel Administration" which is available at the Bacon Library of the American Hospital Association. This classified bibliography should be helpful in providing additional material for personnel administrators, as well as for other supervisors and employes.

The committee on personnel relations has made an invaluable contribution to personnel management within hospitals, and if the content of the seven sections yet to be published compares with the standards already established, we can expect a new concept of hospital personnel relations.—CARL C. LAMLEY.



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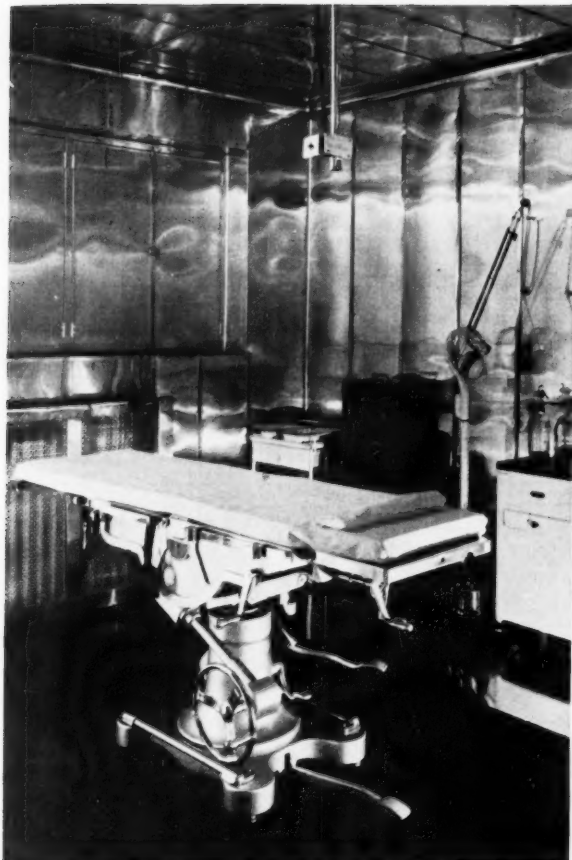
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HOSPITAL TRENDS AND DEVELOPMENTS 1940-1946. Edited by A. C. Bachmeyer, M.D., and Gerhard Hartman, Ph.D. New York: The Commonwealth Fund. 1948. Pp. xiii-819. \$5.50.

A companion volume to "The Hospital in Modern Society" published by the same authors five years ago, this is a recapitulation of the best articles presented in the hospital literature over the period 1940-1946 in the opinion of the authors.

The contributions selected are grouped into sections covering trends in the hospital field generally, administrative problems, specific hospital services, financial control and operation, construction, plant maintenance, and public and community relations generally.

The volume runs to more than 800 pages and, together with its predecessor, constitutes a complete summary of important events and developments in the hospital field in modern times. Every administrator will find this an invaluable reference work which will assist him in arriving at that position from which the day's decisions may be made with confidence that the best available information and thought have been consulted.



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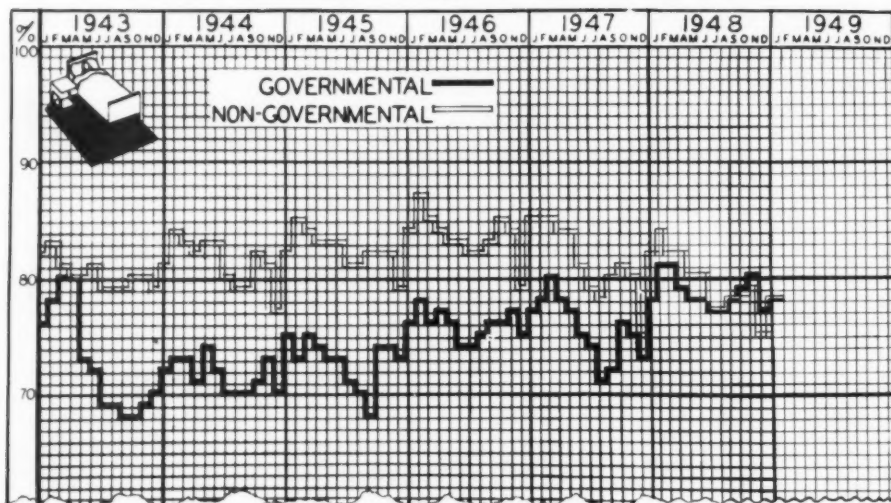


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1949 Construction Projects Total \$105,669,826



Occupancy of nongovernmental hospitals reporting to the Occupancy Chart for January 1949 was 77.5 per cent of capacity—above the seasonal low for the previous month, but lower than for any January in recent years. Governmental

hospitals reported 78.3 per cent occupancy for January, somewhat higher than the January figures for the previous two or three years.

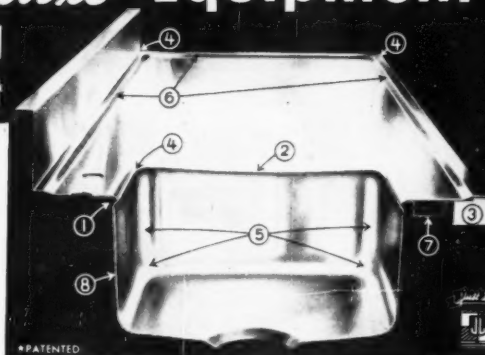
Construction projects reported for the first two periods of 1949 totaled \$105,-

669,826, compared to \$74,745,738 for the same period in 1948. For the latest period, twenty-two new hospitals were reported costing \$31,000,000; twenty-six additions to existing institutions cost \$14,000,000.

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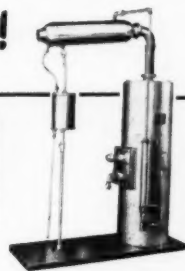
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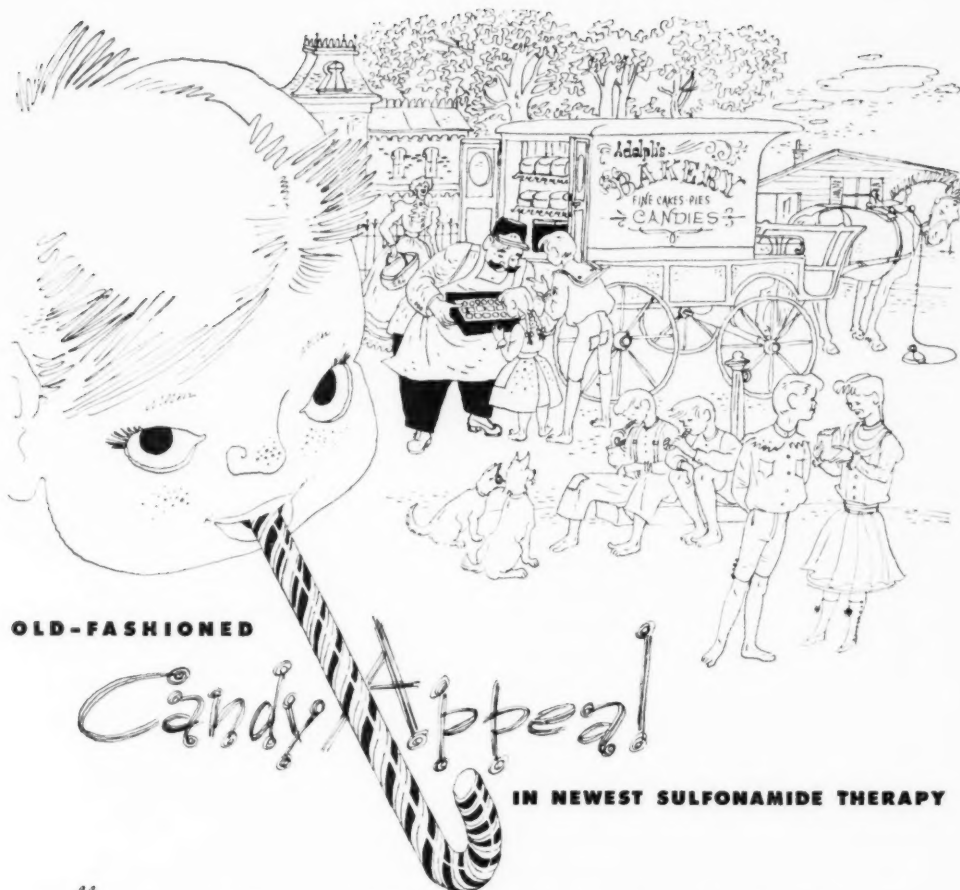
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A Significant Advance in ANTIBIOTIC THERAPY

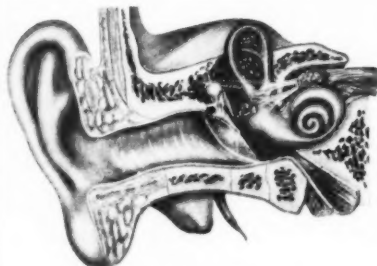
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A NEW, highly purified antibiotic, chemically distinct from streptomycin, with greatly reduced neurotoxicity, Dihydrostreptomycin Merck is especially useful in cases requiring relatively high dosage, such as miliary tuberculosis and tuberculous meningitis.

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MERCK**

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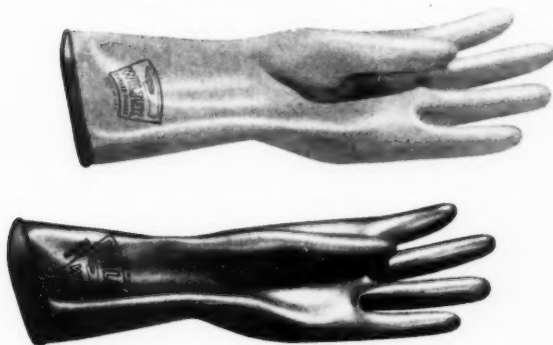
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STIGMINENE* BROMIDE 'Warner' is supplied in 1-cc ampuls of a 1:2000 solution, 0.5 mg. each; cartons of 12 and 50 ampuls.

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- helped improve service without increasing operating costs;
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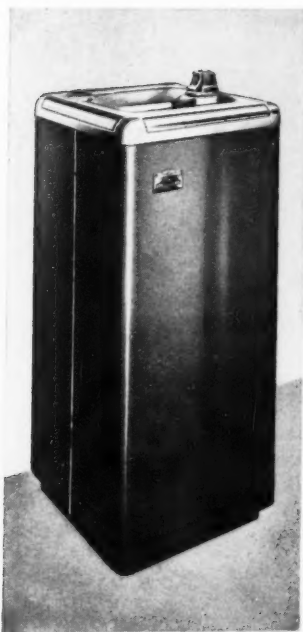
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Protein allowance in such a program is stated to be not less than 1.5 to 1.7 Gm. per Kg. of ideal body weight.¹ A further advantage of the diet high in protein and low in fat and carbohydrate is its greater simplicity; the tedious calculation of calories may be omitted without impairing the efficacy of the program.²

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The protein content of meat is notably high. Regardless of cut or kind, meat provides biologically complete protein able to satisfy the multiple amino acid needs of the body.

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¹ McLester, J. S.: Nutrition and Diet in Health and Disease, ed. 4, Philadelphia and London, W. B. Saunders Company, 1943.

² Kunde, M. M.: The Role of Hormones in the Treatment of Obesity, Ann. Int. Med. 28:971 (May) 1948.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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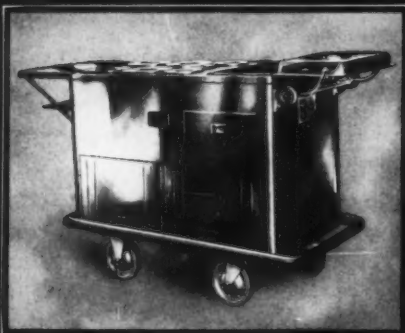
PROMETHEUS

FOOD CONVEYORS

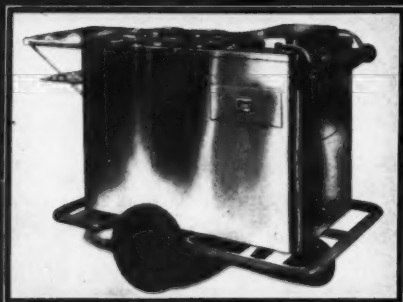
Yes, there's a big swing towards specifying Prometheus when it comes to Food Conveyors.

There is a Prometheus model for every requirement.

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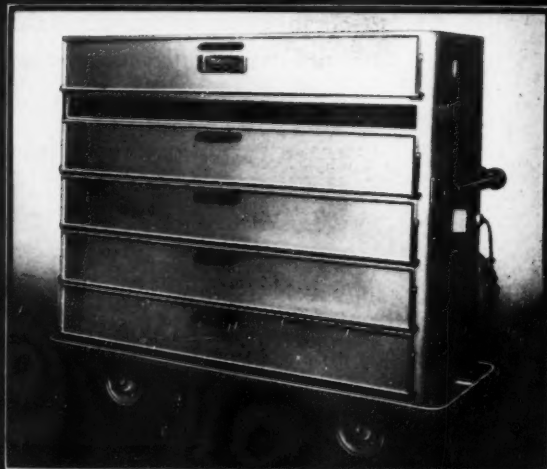


(Above) Model No. 1038 - Serves 60 to 110 patients. Note heated drawer—large enough to accommodate extra meal pan.



(At left) Model No. 1090 - Outdoor Model. 14" pneumatic tires available in various combinations.

(Below) Model No. 1023 - Tray Conveyor. 4 heated shelves, 1 cold compartment holds 20 trays.



Prometheus Food Conveyors are attractive in appearance, compact in size, easy to handle and economical in cost and operation.



Send for descriptive circular giving full details of various designs, capacities and special features.

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OVEN-FRESH FOR HOURS!
cuts hospital costs, speeds service***



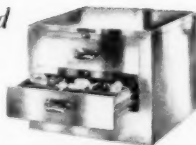
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*Available in Sizes
to Suit Every Hospital Need*

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(above) 27" square, 44" high.

3-DRAWER MODEL 3DS
(not shown) 23" square, 44" high.

2-DRAWER MODEL 2DS
(right) 23" square, 22 1/4" high.



2-DRAWER MODEL
\$225.00 Fair Trade Price
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YOU CAN HOLD cooked foods for hours at their flavorful peak in a "Toastmaster" Roll and Food Warmer! Imagine all the savings you enjoy when you cook in quantity for later serving!

FOR ONE THING, you need less kitchen personnel. So there's less confusion, less duplication of effort. Then, too, foods cooked in quantity cost less to prepare. There's less fuel consumption, less food handling, fewer utensils to wash, the most efficiency from the least cooking equipment.

YES, AND SERVING directly from a "Toastmaster" Roll and Food Warmer in your diet kitchens speeds service and saves time. That means more savings in operating costs.

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YOUR FOOD SERVICE EQUIPMENT DEALER will show you how the "Toastmaster" Roll and Food Warmer cuts cooked-food costs and speeds service, too. Ask him about it today.

TOASTMASTER ROLL and FOOD WARMERS

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types of flooring which grows brighter as
it is polished by traffic. It preserves floor-
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"Floor Maintenance"

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of NEBRASKA**



Food and Nutrition Building, University of Nebraska Agricultural College



Section of award-winning Cafeteria kitchen.



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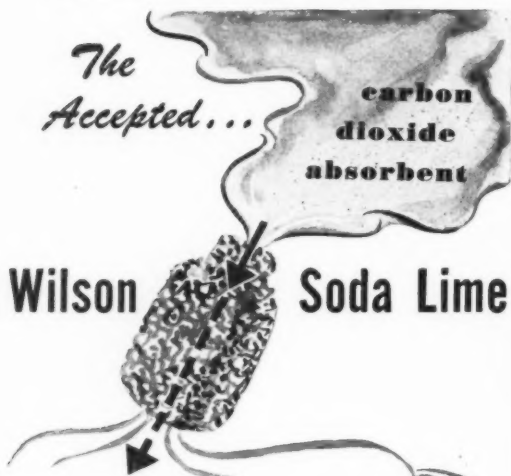


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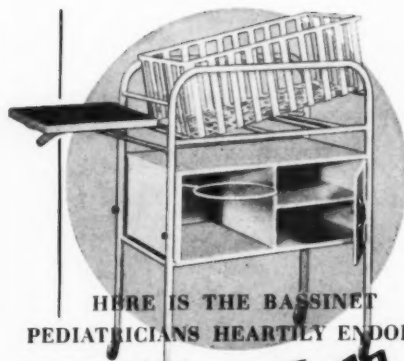


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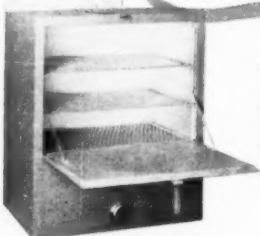
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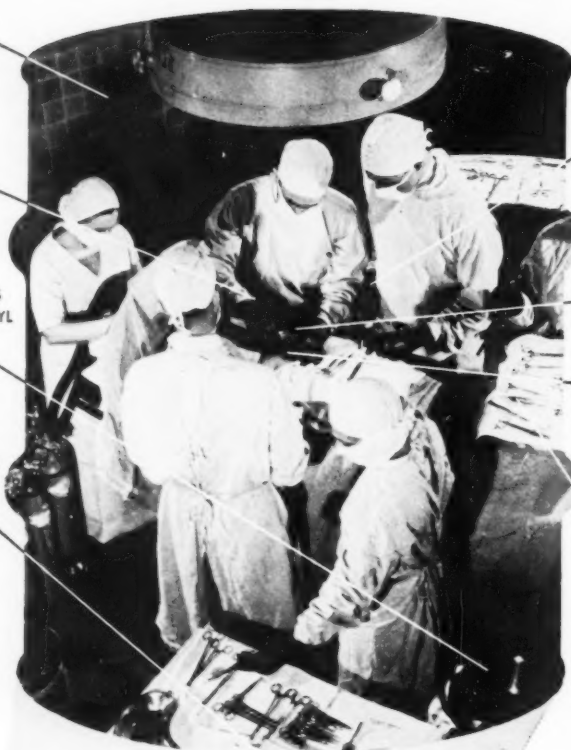
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The Lusterizer is unexcelled for all drinking and table glasses. One girl turns out 700 to 800 per hour, crystal clear without troweling. Removes lipstick and dull film. Saves hot water and washing compound, reduces breakage up to 75%. No extra plumbing needed.

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are ready for immediate use without further sterilizing or handling. This reduces tube breakage, saves nurses' time.

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complete with non-metallic cover, serves as a permanent suture jar for the operating room—saves buying and sterilizing ordinary storage jars.



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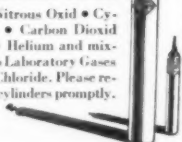
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(Continued on page 222)

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ANESTHETIST—Nurse Anesthetist; to join staff of 460 bed hospital; 44-hour week; pension plan; excellent living accommodations. Apply, Administrator, The Reading Hospital, Reading, Pennsylvania.

ANESTHETISTS—Nurse; midwest; \$250-\$275 to start and maintenance; 175-bed general hospital; department directed by medical anesthetist; state age and experience. MO 37, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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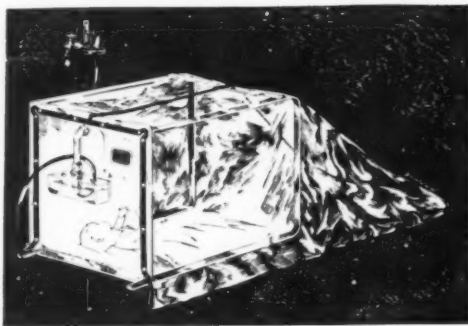
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(Continued on page 224)

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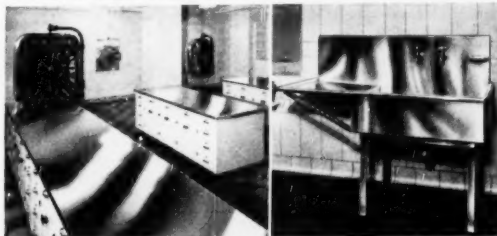
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Cabinet and table tops like these in Wesley Memorial Hospital suggest the broad use of ELKAY Stainless Steel.

Diet kitchens, laboratories and many others benefit by ELKAY standard units as well as custom-made sinks.



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Please send catalog covering additional Hospital items.

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Address _____
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NURSES—Registered; all floors; straight shifts; matrimony has depleted our staff; beginning salary \$225 per month; raises at six month periods for two years; maintenance at reasonable rates if desired; additional pay for surgery; also for evening and night shifts; pleasant working conditions; nearly new, well equipped hospital. Municipal Hospital, Clarinda, Iowa.

NURSES—Graduate; beginning salary \$180 and full maintenance; 16 holidays; two weeks' vacation; five days off per month. Apply Director of Nurses, Essex County Isolation Hospital, Belleville, New Jersey.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary \$200 to \$210 month; full maintenance available for \$10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 59.

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NURSES—Operating room; general duty nurses; head nurses; clinical instructors; \$225 and up depending upon experience and qualifications. Write or telephone, Director of Nursing, White Cross Hospital, Columbus, Ohio.

NURSES—Graduate staff; full or part time in 390-bed hospital connected with medical school; positions open in medical, surgical, pediatric, gynecologic and obstetric departments and in operating room; constantly expanding facilities; 44 hours per week; salary range \$200-\$215 per month for nurses who can rotate on day, evening, and night duty; exceptional opportunity for furthering education in Vanderbilt University. Write: Director of Nursing Service, Vanderbilt University Hospital, Nashville, Tennessee.

NURSES—Staff; eligible for registration in Michigan, U.S.A.; needed for all services in modern 200-bed hospital; salary \$216 per month for 33-hr. wk. 6-month increase. \$10 extra for 3-11 & 11-7 duty; 7 legal holidays; 12 vacation & 10 days sick leave per year; cafeteria meal service; laundry furnished; room available at \$10 per month. Apply, Director of Nurses, General Hospital, Pontiac, Michigan.

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NURSES—Registered; for general duty on all shifts and in all departments of new modern hospital just opening. Address Director of Nurses, East Tennessee Baptist Hospital, Blount Avenue, Knoxville, Tennessee.

NURSES—Registered; for new Pontiac Community Hospital; 52-bed general hospital at Shawville, Quebec; 50 miles from Ottawa. Apply, Superintendent.

NURSES—Staff; for operating room and obstetrical department; immediate opening; good location; State Capitol with many civic advantages; salary open. Apply Director of Nurses, Evangelical Hospital, 6th and Thayer, Bismarck, North Dakota.

NURSES—Staff; for 465-bed general hospital; rotating shift or permanent 3-11 or 11-7 shifts available; on days, salary is \$200 per month; on evenings and nights, \$225 per month; increments offered at six month intervals for 3 years. Apply, Director, School of Nursing, Miami Valley Hospital, Dayton, Ohio.

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(Continued on page 226)



The needle illustrated at left is Torrington Style Number 721—2 3/4". Fine Intestinal, Straight, Taper Point. There are 37 popular styles and 156 sizes in the Torrington Surgeons Needles line. Order from your hospital supply distributor.

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ELASTIC BANDAGE

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TENSOR is available in 2, 2½,
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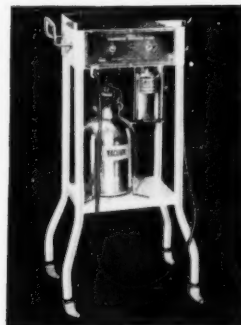
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There is no better
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Attention - Free
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OCCUPATIONAL THERAPISTS—Graduate registered; trained recreation workers for assignment in Illinois State Psychiatric Hospitals, etc. Apply, Miss Bertha E. Schlotter, Room 1500, 160 North LaSalle Street, Chicago 1, Illinois.

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RESIDENTS—Immediately: Pennsylvania license required; excellent for experience on all services of a general hospital; 102 beds; active out-patient department; salary attractive and full maintenance provided. Administrator, Northeastern Hospital, Philadelphia 34, Pennsylvania.

SUPERINTENDENT—To take complete charge of 50-bed general hospital with school for nurses; application giving full details of education; post-graduate training; experience and reference should be sent to Secretary of the Board of Trustees, Miramichi Hospital, Newcastle, N.B., Canada.

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TECHNICIAN—Registered laboratory; newly organized University Student Health Center; 5½-day week; vacation and sick leave plans; good salary and opportunity for advancement; pleasant working conditions; fully equipped laboratory; write giving complete details including salary desired. Student Health Center, University of Nebraska, Lincoln.

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BUSINESS AND MEDICAL REGISTRY (Agency)

Elsie Miller, Director
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DIRECTOR OF NURSES—For 50-bed community hospital near Los Angeles; will soon increase to 100 beds; nursing service requires systematizing and coordination; beautiful location and excellent opportunity for growth and development.

(Continued on page 228)

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Jackson Dishwashers cost *less* to buy, *less* to install, *less* to operate and maintain, and require *less* space. Jackson offers you all these money-saving advantages *plus* high-speed, labor-saving operation and unsurpassed rugged construction and dependability. Find out for yourself why hospitals the nation over have chosen Jackson Dishwashers.

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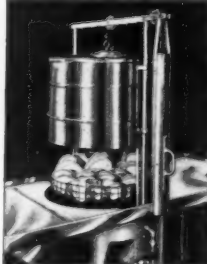
You are *sure* of thorough sanitation with Jackson Dishwashers. (When rinse water is furnished at 180°)

Write Today, to Dept. MH-6 for complete information on all models, including optional equipment such as electric immersion heaters, thermostat controls, and dish tables made to specification.



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For diet kitchens and for central kitchens of smaller hospitals. Capacity 1200 dishes, 2000 glasses or 5000 pieces of silverware per hour. Revolving stainless metal hood enables operator to slide baskets straight through.



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High-speed, heavy duty machine with capacity of 4000 dishes per hour. Counter-balanced stainless metal hood accommodates cafeteria trays as well as all other eating utensils.

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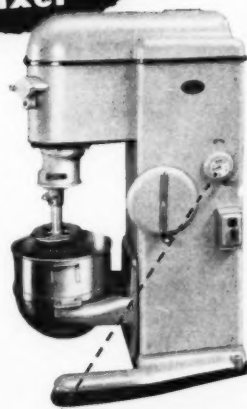
CLEVELAND 5, OHIO

Smoother Mixing



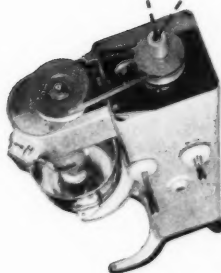
... No Shifting Gears with a
BLAKESLEE
Vertical Mixer

The interesting design above was made by attaching a pencil to a brush beater of a Blakeeslee Vertical Mixer. It illustrates how thoroughly all parts of the bowl are covered, assuring smoother, more even mixing.



Any Speed
at the turn
of a Dial!

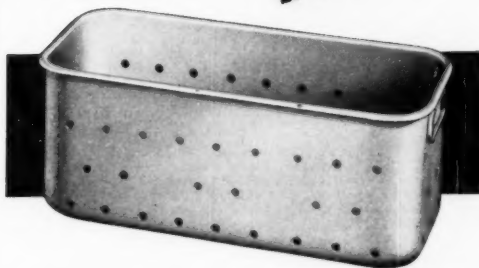
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in either Dura Finish
or Gleaming Stainless-
Clad Construction.



The unique speed-changing mechanism shown at left enables you to get *any* (not just 3 or 4) desired speed between high and low without shifting gears or stopping the motor... Assures a perfect speed for the mixing of all ingredients... a just right speed for every recipe. The strain on a mixer comes from starting and stopping the beater in heavy batches to change mixing speeds. This is eliminated in a Blakeeslee Mixer, adding many years of extra service to these streamlined beauties.

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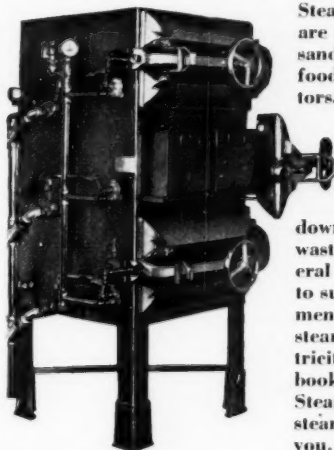
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OPERATING ROOM For county hospital; central California; \$275 for 40-hour week; hospital building new nurses' home but mean-while rooms available in vicinity.

DIETITIAN—Chief dietitian for well-known Arizona hospital; salary \$250, meals and laundry; must have had experience as head of department.

LABORATORY TECHNICIAN Beach town, southern California; hospital has 125 beds; new building, modernly equipped; all procedures common to progressive laboratory; salary \$250 for 5-day 40-hour week.

BUSINESS AND MEDICAL REGISTRY —Continued

ANESTHETIST Oregon; private general hospital of 87 beds and 40 bassinets; \$350; meals available at reasonable rates.

DIRECTOR OF NURSES Southern California county hospital; 300 beds; someone of excellent administrative background, confidence and stability, familiar with daily problems of bedside nursing; \$320 plus modern apartment and full maintenance.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU Miss Elsie Dey, Director 332 Bulkley Building Cleveland, Ohio

SOCIAL AND GUIDANCE DIRECTOR—(a) Near Philadelphia; \$215 maintenance. (b) Student health directors: east; midwest; open August. (c) Assistant directors of nursing; \$250-\$300, maintenance.

DIRECTOR OF NURSING (a) 165-bed hospital; near Boston. (b) 350-bed hospital; Georgia. (c) 150-bed hospital; Florida. (d) 175-bed hospital; eastern Pennsylvania; \$4500. (e) 100-bed Ohio hospital; \$325, maintenance. (f) Sisters hospitals; south, mid-west.

DIRECTORS, NURSING SERVICE—(a) 200-bed hospital; New York. (b) 85-bed hospital; North Carolina. (c) 50-bed hospital; Wisconsin. (d) 75-bed Virginia hospital; \$325.

(Continued on page 230)

INTERSTATE—Continued

DIETITIANS—(a) Administrative. (b) Therapeutic.

HOUSEKEEPER—(a) 200-bed hospital; New England. (b) 100-bed Ohio hospital.

ADMINISTRATOR (a) 100-bed private hospital; mid-west. (b) Assistant; 225-bed Ohio hospital. (c) 125-bed hospital; New England.

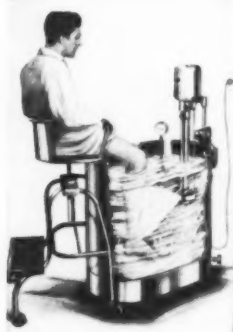
BUSINESS MANAGER—500-bed hospital; eastern metropolis; hotel and personnel management experience desired; salary open.

EDUCATIONAL DIRECTORS—\$275-\$325, maintenance.

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TECHNICIANS—(a) Chief laboratory; Ohio; \$325. (b) X-ray; \$200, maintenance; Michigan. (c) Physiotherapy; to organize new department; mid-west. (d) Occupational therapy; south.

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COMBINATION ARM, LEG & HIP UNIT
Mobile Model HM 200
(An Improved Whirlpool Bath)



HYDR° MASSAGE SUBAQUA THERAPY EQUIPMENT

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Ille Tanks are increasingly preferred by specialists in physical medicine. The remarkable efficiency, safety, comfort and economy of operation "built" into Ille equipment

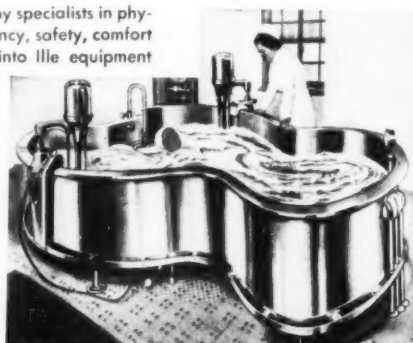
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OTHER ILLE UNITS: New Improved Paraffin Bath, Mobile Sitz Bath, Folding Thermostatic Bed Tent, etc.

*Currence, John D.; New York State J. of Med., 48:2044, Sept. 15, 1940



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FULL BODY IMMERSION HYDROTHERAPY TANK UNIT—Model HM 801

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Supertex Shades are made only for institutional use—Hospitals, Schools, etc. Made of a special long stable cotton duck, vat dyed—not paint dipped. Supertex fabric stands use and abuse three or four times longer than ordinary shades. They cost a little more—they're worth a lot more.

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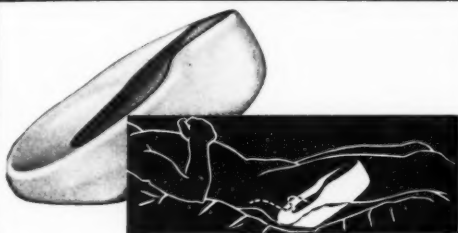
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Relax BED PANS ARE AN AID TO PATIENT RECOVERY

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Hot or cold, Alconox is equally effective. It actually lifts off dirt, grime and grease faster than anything you have ever tried.

SAVES ENERGY, SAVES TIME

Just wash and rinse. Toweling practically unnecessary. Economical, too—one spoonful makes a gallon of active cleanser ready to go to work on your toughest job.

Rubber gloves are unnecessary while cleaning with ALCONOX because ALCONOX is kind and mild to the hands. Quick self-acting penetration gives Nurse additional time for other important duties.

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"It does a swell job and saves us many hours."

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50-lb. bag, 36c per lb.

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ADMINISTRATORS—(a) Voluntary hospital, approximately 500 beds; expansion program; teaching affiliation; east. (b) General hospital, 200 beds; town of 100,000; west; \$8000-\$12,000. (c) Medical director; hospital specializing in cancerology; university town; middle west. (d) Assistant administrator; fairly large hospital; California. (e) General 200-bed hospital undergoing reorganization; town 35,000, southeast modern, three-bedroom home available. (f) General 75-bed hospital to be opened, April; only hospital in town of 20,000; middle west. (g) Business manager; 300-bed hospital in midst of two million dollar building program; medical center; middle west. (h) General hospital; expansion program will increase present capacity of 250 beds to 400; college town; middle west. (i) Business administrator; 10-man clinic; southwest. (j) Executive secretary; state society of national organization; middle west. (k) Business manager; voluntary hospital, 650 beds; east. (l) Purchasing agent; 300-bed hospital; university center; \$4000-\$5000; east. MH3-1.

MEDICAL BUREAU—Continued

ADMINISTRATORS-NURSES—(a) Small general hospital now under construction; residential town, middle west. (b) Assistant to lay administrator; 300-bed hospital; university graduate preferred. MH3-2.

ANESTHETISTS—(a) Two; modern hospital, fairly large size; operated by group of outstanding specialists; medical center; west. (b) General hospital, 500 beds; medical anesthesiologist in charge; four medical residents in training; east. (c) Instructors in anesthesiology; twenty students; approved school. (d) To become associated, 12-man group; small modern hospital; \$4200, maintenance; southwest. (e) To join staff, department of anesthesiology, 15-man clinic; college town of 50,000, west. (f) To assist American Board Surgeon; college town, east. MH3-3.

DIETITIANS—(a) Chief; general 200-bed hospital; industrial city of 125,000, middle west; \$350. (b) Associate nutrition consultant; department of health; outside continental United States; \$4800-\$6000. (c) Food production dietitian; cafeteria of large industrial company; university center, east. (d) Dietitian to establish and conduct dietary outpatient department; fairly large hospital; Detroit area. (e) Chief and assistant dietitian; one of the leading hospitals in the Chicago area. (f) Department of welfare, middle western city; duties include directing program of nutrition education. MH3-4.

MEDICAL BUREAU—Continued

DIRECTORS OF NURSES—(a) Large private hospital, 300 students, competent organizer required; educational center, city of 400,000; \$5000-\$6000, maintenance. (b) General hospital; patient census 150; staff, 80 graduate nurses; suburb middle western metropolis; around \$5000, maintenance, private apartment. (c) Fairly large hospital; all-graduate staff; winter resort town, California. (d) Hospital of 450 beds; unit of university group; expansion program; east; \$6000. (e) Voluntary hospital of 400 beds; teaching affiliations; 200 students; university center, south. (f) Private sanitarium specializing in nervous diseases; excellent staff; university medical center; \$4200, maintenance; middle west. (g) Assistant director; no school; large medical program involving 200-bed hospital, outpatient department, public health service; west. (h) One of the most important appointments in profession; nationally known hospital having teaching affiliations; associate directors in charge of school and nursing service; \$7200, maintenance. MH3-5.

EXECUTIVE HOUSEKEEPERS—(a) Teaching hospital of nearly 500 beds; outstanding woman required. (b) Hospital operated by group of outstanding physicians; college town, east. MH3-6.

EXECUTIVE SECRETARY—(a) State board of nurse examiners; duties include surveying and counseling; \$4000. MH3-7.

(Continued on page 232)

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- ★ **Super SHINE-ALL ...**
A neutral chemical cleaner—not a soap—does not have to be rinsed
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A floor dressing—not a greasy floor oil. Leaves a protective coating
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A penetrating seal that water proofs wood floors and prevents breaking down of cell structure
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A marvelous water and weatherproof seal for terrazzo, tile, marble, slate and cement floors

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Electric twin brush scrubbing, polishing and waxing machine. A model for every purpose. 16 inch, 19 inch and 22 inch.

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That is
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TO 3
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WANT ADVERTISEMENTS

POSITIONS OPEN

MEDICAL BUREAU—Continued

FACULTY APPOINTMENTS—(a) Educational director; 200 students; university medical center; \$4500. (b) Assistant professor to coordinate teaching in the major program in nursing education; university school; \$5000; 10-month year. (c) Instructors in tuberculosis and psychiatric nursing; large teaching hospital; east; \$4200. (d) Instructor of supplementary staff, particularly nursing aides; large teaching hospital; faculty rank; east. (e) Science; small school; new laboratories, teaching equipment; residential town few miles from university center; middle west. (f) Instructor—nursing arts; university hospital; 350 students; possibility of being appointed assistant professor. (g) Clinical instructor; department of nursing education, state university; classes limited to graduate nurses; faculty rank; south. (h) Educational director; 270 students; staff of eight instructors; Canada. MH3-8.

PHARMACISTS—(a) General 350-bed hospital; large city, south; \$300, maintenance. (b) Chief; large municipal hospital; New England. (c) Hospital of 250 beds; large city outside continental United States. MH3-9.

MEDICAL BUREAU—Continued

RECORD LIBRARIANS—(a) Chief; university medical center; should be capable of reorganizing department; \$4000. (b) Large general hospital; three assistants; southern California. (c) Chief; 500-bed hospital; town, 150,000, near university center; \$3000, maintenance; east. (d) Small hospital located in large city of United States dependency; tropical climate. MH3-10.

SOCIAL DIRECTOR—Social and guidance director, school of nursing, large hospital; preferably B.S. Degree. MH3-11.

SUPERVISORS—(a) In medicine, pediatrics, operating room, obstetrics, psychiatry; large teaching hospital; all positions carry university appointments. (b) Orthopedic; 250-bed hospital; town of 125,000, middle west; \$3600. (c) Operating room; one of California's leading hospitals; operations average 250 monthly; no teaching. (d) Night; fairly large hospital; residential town, short distances from Philadelphia, Baltimore; \$3400-\$4200. (e) Pediatric; one of the leading hospitals, Chicago area. (f) Supervisor of large active floor of operating rooms; New York City. MH3-12.

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SUPERINTENDENTS—(a) Physician or Nurse; small new hospital; east. (b) Assistant layman; large hospital; New York state.

ANESTHETISTS—(a) Small hospital; Delaware; to \$300, complete maintenance. (b) 125-bed; Wisconsin; \$325; three anesthetists employed; short hours.

DIRECTORS OF NURSING—(a) 200 beds; New Jersey; \$4500; maintenance includes apartment. (b) 80 beds; New York state; graduate staff.

DIETITIANS—(a) Chief; 55 beds; Pennsylvania; \$200; maintenance. (b) Assistant; New York; \$190; maintenance.

EDUCATIONAL DIRECTOR—General hospital; University City; \$4400.

INSTRUCTORS—Clinical - Science - Nursing Arts; 150 beds; Pennsylvania; \$275.

MEDICAL SOCIAL SERVICE CASE WORKER—New England; starting \$2600.

(Continued on page 234)

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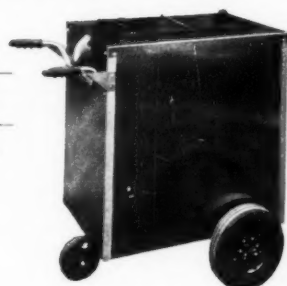
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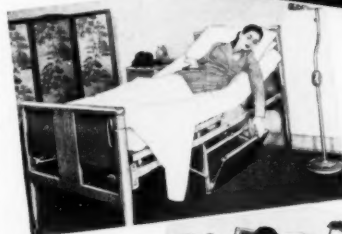
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PHARMACISTS—(a) Chief; New Jersey: starting \$300. (b) Chief; Pennsylvania: \$325. (c) Assistant; Maryland: \$250.

RECORD LIBRARIANS—(a) Chief; 100 beds; Delaware: \$200; maintenance. (b) 150 beds; Pennsylvania: \$275. (c) Small hospital; New Jersey.

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SHAY AGENCY—Continued

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DIETITIAN—Middle west; doctor's office; to make up allergy, diabetic, other diets; full time job; salary based on qualifications; prefers registered; one with degree satisfactory.

(Continued on page 236)

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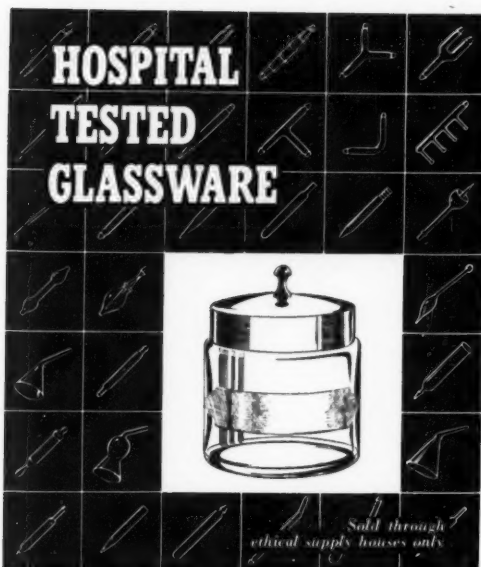
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Brushes, Pads,
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(Formerly Aznoe's)
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185 North Wabash Avenue
Chicago 1, Illinois

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DIRECTORS OF NURSING—(a) 200-bed approved California hospital; attractive college town; Pacific coast; \$4000 maintenance. (b) 200-bed approved Florida hospital; \$5000. (c) 100-bed approved Illinois hospital, college town; \$4200 maintenance. (d) 200-bed approved hospital with university affiliation; northwest; \$4,500. (e) 100-bed approved New York hospital; college affiliation; \$4000 maintenance.

WOODWARD—Continued

DIETITIANS—(a) Food production dietitian; large cafeteria; east; \$3100 yearly. (b) Chief; 200-bed approved Ohio hospital; \$3600 yearly. (c) 100-bed hospital; eastern mountain resort region; \$3600. (d) Approved hospital Florida resort town; \$3000. (e) 100-bed approved Texas hospital; \$3600 maintenance. (f) 100-bed tuberculosis hospital; southern California; \$3,000. (g) 100-bed hospital; college town near Chicago; \$3000 maintenance.

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PHARMACISTS—(a) Florida medical center; \$4800 yearly. (b) 100-bed approved hospital southeastern college town; \$4200. (c) 200-bed approved hospital; residential community near New York; \$2600 maintenance. (d) 300-bed hospital; east coast; \$3800 maintenance.

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(Continued on page 238)

WOODWARD—Continued

RECORD LIBRARIANS—(a) Large, approved hospital southern Florida; to \$3000. (b) 100-bed approved hospital; Louisiana medical center; \$3000 maintenance. (c) 400-bed approved hospital; east coast; \$3200; forty-hour week. (d) 350-bed approved hospital in Philadelphia area; \$3000 maintenance. (e) 100-bed approved Texas hospital; \$3600.

SUPERVISORS—(a) Night; 70-bed approved hospital; eastern college town; \$3000 maintenance. (b) Obstetrical; \$3000; new air conditioned hospital near Houston. (c) Operating room; 100-bed approved hospital, Chicago suburb; \$3000 maintenance.

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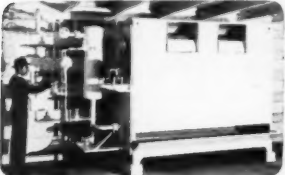
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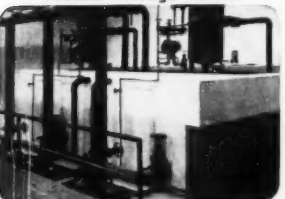
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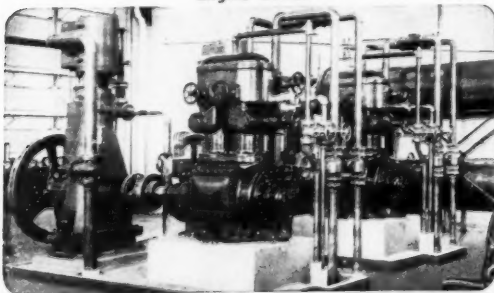
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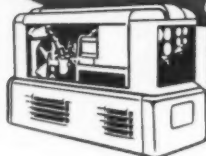
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(Continued on page 240)

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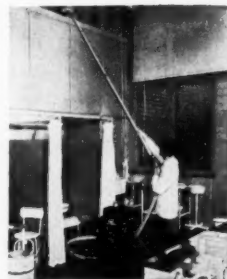
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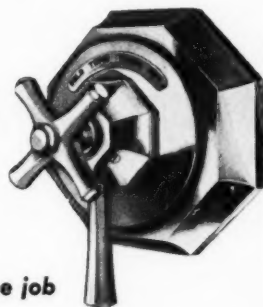
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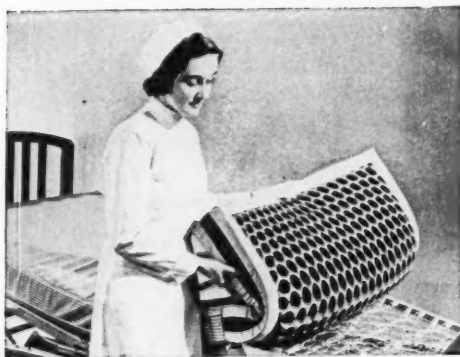
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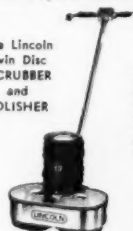
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What's New for Hospitals

MARCH 1949

Edited by BESSIE COVERT

"Slide-Out" Washer



The "Slide-Out" feature of Troy Electromatic and Troy Electromannual washers is designed to facilitate unloading by eliminating the necessity of stooping and lifting. It simplifies the removal of laundry from the washer while washing clothes cleaner. With the "Slide-Out" feature the load not only receives the drop and tumble action of an open pocket washer, but is subjected to a washboard action as the clothes slide down the ribbed partition as well as a squeezing action on the upward rotation of the cylinder when the load is pressed against the perforated partition.

"Slide-Out" washers are available in three sizes: 42 by 84 inches, 42 by 54 inches and 42 by 36 inches which makes them suitable for small as well as large hospitals. **Troy Laundry Machinery Div., American Machine & Metals, Inc., Dept. MH, East Moline, Ill. (Key No. 481)**

Sterile Suture Pack

Gentian Violet has been added to the sterilizing fluid in which Ethicon suture tubes are immersed to facilitate the detection of cracked or broken tubes. Addition of 0.001 per cent of Gentian Violet to the sterilizing fluid causes a purplish discoloration on the inside of any tube that is damaged, thus immediately indicating the condition. **Ethicon Suture Laboratories, Dept. MH, New Brunswick, N. J. (Key No. 482)**

Improved Round Sponges

Curity Rondic Sponges, the ball shaped, general purpose machine made sponges, are now being made by a new process. Ends of the fine-mesh gauze covering the cotton ball are tucked in-

side the sponge by a mechanical process and held securely, virtually eliminating the possibility of loose threads at the point of closure. The new Rondic Sponges are available in small, medium, large and extra large sizes and are packed 1000 sponges to a box, 4 boxes to a case. **Bauer & Black, Dept. MH, 2500 S. Dearborn St., Chicago 16. (Key No. 483)**

Entrance Doors

The new Fenestra stock, hollow-metal entrance doors with large glass light are furnished in one standardized size, 3 feet by 7 feet, for use in single or double openings, and are supplied with a standard cylinder lock. The doors may be hinged right or left to swing in or out and come complete with frames



and hardware machined, fitted and ready to assemble. Attractive bronze push and pull bars and bronze ball-bearing hinges are available if desired. The doors are designed for entrance, exit, service door and other locations. **Detroit Steel Products Co., Dept. MH, 2250 E. Grand Blvd., Detroit 11, Mich. (Key No. 484)**

Dish Drying Machine

The new Colt C-300 dish drying machine has been designed primarily for use with the Colt Autosan C-22 or C-3 dishwashing machines. The dishes are carried through the drier on an inclined belt, to which they are transferred from the washer, and are dried by the application from above and below the dishes of compressed air. The bulk of the water is thus removed, and remaining moisture film evaporates as a result of residual heat of the dish and moving air within the drier.

The new unit is constructed of stainless steel and there is a door in both front and back of the enclosure for easy cleaning. **Colt's Mfg. Co., Dept. MH, Hartford 15, Conn. (Key No. 485)**

O-syl Disinfectant

O-syl is a new disinfectant which is described as a non-irritating, non-caustic, non-specific germicide that successfully and promptly attacks the many pathogenic bacteria and fungi whose elimination is the object of disinfection and antiseptics. It is designed for disinfecting floors, walls, furniture, bedding, surgical instruments and rubber goods, dishes and utensils; for preparing obstetrical patients; as an antiseptic hand rinse which does not burn or irritate, and for other disinfectant and germicidal requirements. It is economical to use since it is effective for general use when diluted 100 times. O-syl is nearly odorless, leaving no disagreeable odor after disinfection. **Lehn and Fink Products Corp., Dept. MH, 445 Park Ave., New York 22. (Key No. 486)**

Aero-Kromayer Wall Type Lamp

The new Aero-Kromayer Wall Type Lamp for orificial application is compact in makeup and efficient in operation. Since it is readily attached to the wall, floor space is saved. A novel reel arrangement within the control eliminates the fouling of cords.

The newly designed model has higher intensity, produces more ultraviolet through the applicators, has a self-lighting burner which operates in any position and is streamlined and attractive in appearance. The applicator rests in



a holder at the bottom of the unit. **Hanovia Chemical & Mfg. Co., Dept. MH, Newark 5, N. J. (Key No. 487)**

Electric Typewriter



The new Remington Electric De Luxe typewriter has been designed to permit maximum typing efficiency and output. All controls are centered on one panel which faces the operator and is immediately at her fingertips. The constant-speed electric motor ensures uniformity of speed and type impression regardless of power drains. The scientifically engineered keyboard has "finger-tip" keys which have been designed to conform to the operator's fingers. This feature is said to produce maximum speed and reduce operator fatigue.

While both pica and elite typefaces are available on the new electric machine, a new typeface, known as Remington Rand Type, has been especially developed for the machine. It is designed to enable faster reading and clearer copies. The machine is made to fit all standard typewriter desks and is described as an all-purpose typewriter. Remington Rand Inc., Typewriter Div., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 488)

Improved Cotton Suture

Gudebrod's Hand-Craft Cotton Suture is a new, improved and stronger cotton suture. U.S.P. graded 5-0 to 2, the new suture is remarkably uniform in strength and size and tests show the breakage points to be considerably stronger than cotton sewing threads. The new Hand-Craft Cotton suture is identified by its light blue color which has been approved by the Food and Drug Administration and is non-toxic to tissue. Gudebrod Bros. Silk Co., Inc., Dept. MH, 225 W. 34th St., New York 1. (Key No. 489)

Paint Brushes

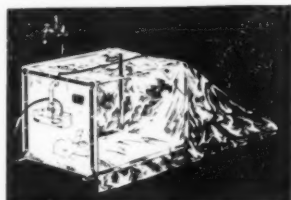
Two new lines of paint brushes announced by Devoe & Reynolds will be of interest to the administrator and the maintenance chief. The result of research and experimentation, the new brushes were developed to conform to specifications obtained from hundreds of actual users. Lighter-weight construction, functionally shaped handles and non-marking bristles are some of the

improvements offered in the Black Prince and Forty-Niner lines. The former is a featherweight wall brush in sizes 3½ and 4 inch and the latter is a wall brush and flat varnish brush available in seven sizes ranging from 1 to 3 inches. Devoe & Reynolds Co., Inc., Superkleen Brush Div., Dept. MH, 44th St. & 1st Ave., New York 17. (Key No. 490)

Croupette Croup Tent

The Croupette is a new humidification unit for use in the treatment of respiratory ailments where high humidity or oxygen concentrations are indicated. A nearly invisible, cool nebulized spray is provided which is almost completely evaporated within the canopy without heavy condensation of water particles on walls, clothing and bedding.

The Croupette can be folded flat for storage and is adjustable for use on any standard sized crib or bed. The transparent canopy provides complete visibility of the patient and gives the patient added comfort. There are no mechanical parts to get out of order and the unit permits humidity from 93 to 99 per cent with minimum condensa-



tion or oxygen concentrations from 30 to 50 per cent at a fixed flow of 4 liters per minute. Both humidity and oxygen can be provided and the unit can also be operated with compressed air or oxygen-helium mixtures. Air-Shields, Inc., Dept. MH, Hatboro, Pa. (Key No. 491)

Steri-Seal Nursing Unit

The Steri-Seal nursing unit consists of a bottle, nipple and plastic cap. When feedings are prepared, the nipple is placed on the bottle in the upright position ready for use and a plastic cover is placed over it during storage. When the feeding is to be used, the plastic cover is removed and the nipple, which is retractable and has folded down beneath the cap, pops up ready for use without further handling.

The nipple features the Con-trol-Flo, consisting of three vent slots which can be adjusted to slow, medium or fast by simply turning the nipple to select the flow wanted. Steri-Seal, Dept. MH, 333 E. Long St., Columbus 15, Ohio. (Key No. 492)

Alcohol Container

A new convenient container for U.S.I. Ethyl Alcohol, U.S.P. has been developed for users of small packages. The new glass bottle contains 1.21 wine gallons or 2.3 proof gallons of U.S.I. Ethyl Alcohol, 190 proof, fully conforming with the U.S.P. XIII specifications for pure ethyl alcohol. The specially designed outer package is made tamper-proof for the user's protection. U. S. Industrial Chemicals, Inc., Dept. MH, 60 E. 42nd St., New York 17. (Key No. 493)

Leader Luminaire

The new Leader luminaire SM-440 provides 40 per cent indirect light diffusion and 60 per cent direct. It is designed to provide equalized and gentle brilliance diffused over great areas in all directions.

The all metal fixture provides shielding with metal louvers which swing down or can be entirely removed. Alzac reflectors and louvers are available if desired. The unit is constructed of 20 gauge steel, finished in high gloss white baked-on enamel. Where desired, the new unit is available with a built-in germicidal lamp which is not visible when the fixture is hung at standard lighting levels. Leader Electric Co., Dept. MH, 3500 N. Kedzie Ave., Chicago 18. (Key No. 494)

Floor Machine

The new model C-18 floor machine recently announced by The Kent Company has a brush spread of 18½ inches and is equipped with a ¼ h.p. motor. The offset motor design counter-balances the handle, thus evenly distributing the weight of the machine and facilitating its operation. All moving parts are mounted on ball or Timken Roller bearings, the motor is dustproof and waterproof and the two gears run in a continuous bath of grease. The adjustable handle is equipped with a safety switch which can be operated by either or both



hands. In addition, the C-18 has all of the fine features of earlier Kent models. The Kent Company, Inc., Dept. MH, Rome, N. Y. (Key No. 495)

Elastic Bandage

The new Super-Ward rubber reinforced elastic bandage is a service weight product designed to meet the routine needs of hospitals and clinics. Reinforced with rubber threads, the bandage ensures constant support and is described as desirable for pressure dressings or when applied to a knee, ankle or other part of the body where motion of the patient might cause a bandage to slip.

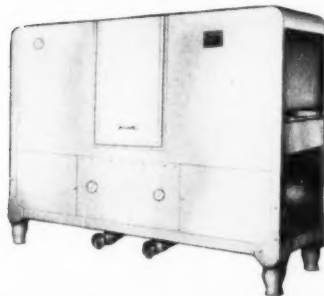
The Super-Ward bandage is unaffected by perspiration, oils, grease, sterilization or washing. It is boxed especially for hospital use, one dozen to a package, two B-D clips attached to each bandage. This neutral color bandage is available in 2, 2½, 3 and 4 inch widths and is economically priced. **Becton, Dickinson & Co., Dept. MH, Rutherford, N. J. (Key No. 496)**

Insect-Killing Paint

Smartbrite is the name of a quality oil base paint incorporating DDT to make it effective in eliminating flies, spiders and other insects from areas covered with the product. Preliminary research showed surfaces painted with Smartbrite remaining insect free after 24 months. The same surfaces are harmless to humans or animals. Smartbrite covers up to 450 square feet to the gallon and has excellent wearing qualities. It is available in white and six colors and is designed for use on interior surfaces. **Yates & Smart Paint Co., Dept. MH, 450 Fifth St., San Francisco 18, Calif. (Key No. 497)**

Dishwashing Machine

The new Model 40-H Champion dishwashing machine is a double tank machine, 72 by 28¼ inches in size with a capacity of 7200 dishes per hour. It operates automatically with racks progressed through the machine by means of a stainless steel pawl bar with brass



lugs engaging each rack. The mechanism for operating this reciprocating pawl bar is actuated by a power take-off from

the pump shaft. A spring-loaded slip clutch, sealed in oil, which is easily adjustable, protects the machine from overload damage. This type of automatic dishwasher is also available in a single tank machine and in two sizes larger than the Model 40-H. **Champion Dish Washing Machine Co., Dept. MH, Erie, Pa. (Key No. 498)**

Chestpirator

The Chestpirator is a portable iron lung which is lightweight and compact and is designed to give artificial respiration quickly and efficiently. The chest piece weighing only 15 pounds and the heavy duty power plant with Oilite bearings which require no lubrication and with adjustable respiration speeds from 14 to 30 per minute can be quickly transported as needed. Hand operation when power is not available is easily handled. The unit can be applied and put into operation in a mini-



mum of time. When not in use it takes up little storage space.

The patient rests comfortably on his regular hospital bed when using the Chestpirator and nursing is simplified since arms, legs and lower body are free for examination and treatment. The new Spiralock Collar, which requires no stretching and fits all neck sizes, is used on the Chestpirator for quick application and greater patient comfort. **Iron Lung Co. of America, Dept. MH, 19 Walnut St., Boston 32, Mass. (Key No. 499)**

Plastic Upholstery

Boltaflex is an all-plastic upholstering material which is designed to withstand rough usage, not to crack, peel or craze in any temperature, to be waterproof, resistant to stains, food and alcohol, and to be easily cleaned. It does not support combustion and can be draped, welted or channeled. It is now available in tufted form as Sealtuft Boltaflex, developed by a new process which heat-fuses the standard Boltaflex material to a layer of fire-proofed cotton and a sheet of thin film plastic. It is available in a wide variety of colorfast, attractive colors designed to blend with any decorating plan. **Bolta Products Sales, Inc., Dept. MH, Lawrence, Mass. (Key No. 500)**

Rosslyn Metal Cooking Utensils



A new line of quality cooking utensils is being made of the new Rosslyn Metal. Made with a copper core which runs all through the sides and bottom, the utensils have inner and outer surfaces of stainless steel which provides a hard, bright metal cover that resists corrosion and is easily cleaned. The copper core spreads the heat quickly and evenly through the vessels in all directions.

These Crusader Stainless Copper Core cooking utensils are being produced in frying pans of 3 diameter sizes, sauce pans and pots in 5 capacity sizes and stock pots in 3 sizes. **Lalance & Grosjean Mfg. Co., Dept. MH, 92nd St. & Atlantic Ave., Woodhaven 21, N. Y. (Key No. 501)**

Triad Power Plant

The new Triad turbine and hydro-electric plant is designed to be used as a standby unit in case of power failure. Installation is simple since the unit, employing water pressure for the generation of electricity, is cut in on the standard water main with an automatic control that starts the generator upon the failure of the normal power source. The unit requires a minimum of attention, is fully automatic and practically instantaneous in the assumption of its function when needed. The plant can also be used as the power source where water pressure is available and the institution prefers to make its own power. **Northwest Machine Works, Dept. MH, 1727 S.E. 11th Ave., Portland 14, Ore. (Key No. 502)**

Alcohol-Resistant Wax

A new alcohol-resistant wax, which is designed to reduce floor maintenance in rooms where alcohol is used, has been proved impervious to alcohol under severest tests. This floor-protective wax can be safely used on any type of flooring since it is a water-dispersed Carnauba wax containing no harmful solvents. It is concentrated, self-leveling and does not increase slipperiness of floor coverings. The new wax should prove effective in laboratories, kitchens, operating rooms and other areas. **Huntington Laboratories, Inc., Dept. MH, Huntington, Ind. (Key No. 503)**

Unicide

Unicide is described as a new all-purpose medical germicide. It is a powerful ammonium quaternary disinfectant, high in bactericidal quality and low in toxicity, containing carbamide, a special ingredient exerting emollient action on the skin. It is colorless, odorless and indefinitely stable, non-staining and non-irritating to human tissue. A highly concentrated germicide in powder form, Unicide can be mixed with water for aqueous solutions or with alcohol for tinctures. It is designed for cold disinfection of surgical instruments without danger of rusting, pitting or dulling the cutting edges. In tincture form Unicide can be used in most surgical and medical procedures requiring skin antiseptics. The aqueous form is used for irrigations, instillations, wet dressings and similar procedures.

Unicide is supplied in the new "Uni-Pak," an accurately pre-measured amount of powder hermetically sealed in a plastic film container ready for instant use without measuring or weighing. **United Surgical Supplies Co., Dept. MH, 160 E. 56th St., New York 22. (Key No. 504)**

Gravity-Feed Slicer

The new Model 805 Gravity-Feed Slicer is designed to combine the best features of the gravity principle with precision slicing. It provides a fast, easy way to slice hot and cold meats, fruits and vegetables, bread and cheese down to the last piece.

A large removable receiving tray of stainless steel extends far enough under the knife to permit of slices stacking in the center. The carbon steel knife slices in any thickness up to $\frac{1}{4}$ inch and thickness is easily set by an illuminated dial adjuster. An automatic concealed sharpener is attached to the machine and the motor is totally enclosed. The new slicer has no corners or crevices to collect crumbs and is easily taken apart for cleaning. All parts of Model 805 are made of stainless steel, anodized aluminum or chrome with base finished in white-baked-on Dulux. **U.S. Slicing Machine Co., Inc., Dept. MH, LaPorte, Ind. (Key No. 505)**

Laundry Antiseptic and Deodorant

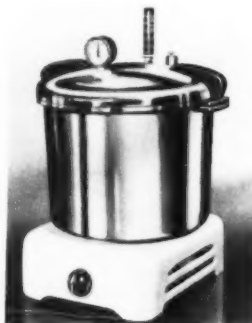
Antiseptin, developed for use by the Navy during the war, is now being introduced for use by hospital and commercial laundries to inhibit bacterial growth in laundered fabrics. No new equipment is required for its use as Antiseptin is added as a cold rinse after the regular laundering cycle. In solution it is a clear, straw-colored fluid which is in-

stantly soluble in water and may be used on all fabrics safely.

In addition to its bactericidal qualities, Antiseptin has proved to be an effective deodorant when used in the indicated dilutions for bactericidal action. It not only destroys existing bacteria and opposes sepsis but inhibits bacterial growth in laundered fabrics for long periods of time. **Carman & Co., Inc., Dept. MH, 629 W. 27th St., New York 1. (Key No. 506)**

Portable Steam Sterilizer

The new Presto Autoclave is a low priced, portable steam sterilizer for use in the laboratory or other location where a small autoclave would be serviceable. The autoclave is made from special, high quality cast aluminum alloy, with sterilizing crate and rack of stainless steel. The unit is light in weight and easily portable. It can be used on any type of heating element and is easy to operate



since the seal is opened or closed by a simple turn. It has scientifically designed pressure control weight, over-pressure plug and pressure gauge. A thermometer can be installed if desired. The new autoclave will serve to sterilize instruments, utensils and dressings. **National Pressure Cooker Co., Dept. MH, Eau Claire, Wis. (Key No. 507)**

Diagnostic X-Ray Apparatus—A Correction

The Maxiscope 500, manufactured by General Electric X-Ray Corporation, 4855 W. McGee Ave., Milwaukee 14, Wis., was described in the February issue in this department as having high voltage, increased from 100 to 300 kv. Since this is diagnostic and not deep therapy apparatus our error was probably obvious but we regret its appearance and wish to clarify the matter by giving the correct information: the new high voltage tube with the Maxiscope 500 operates at 130 kv. **The Editor.**

Pharmaceuticals

Dihydrostreptomycin

Dihydrostreptomycin Squibb is a potent antibiotic compound derived from streptomycin by reduction with hydrogen. It is less neurotoxic than streptomycin and has been well tolerated by patients showing allergic reactions to streptomycin. It is designed for intramuscular injection as an adjunct to other measures in the treatment of tuberculosis. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 508)**

Antihemophilic Globulin

Antihemophilic Globulin is indicated for the treatment of hemorrhagic crises in proved hemophiliacs by intravenous injection. Derived from the fractionation of fresh normal human plasma, the product is of homologous origin and therefore can be given without danger of foreign protein reactions. It is supplied dry in a 20 cc. vial to be dissolved in sterile, pyrogen-free saline or distilled water. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 509)**

Graminasin

Graminasin is an antibiotic nasal decongestant containing gramicidin, the principal active fraction of tyrothricin, in aqueous solution with desoxyephedrine hydrochloride. It is designed for the relief of nasal congestion and possible prevention of infection from the secondary invaders of the common cold. It is supplied in dropper bottles, each containing 15 cc. of Graminasin. **Schering Corp., Dept. MH, Bloomfield, N. J. (Key No. 510)**

Penicillin Tablets

The new Crystalline Penicillin Tablets, 50,000 unit triturates, are completely soluble in water. They provide excellent oral therapy for children, since they readily dissolve in formula or orange juice, and can be used sublingually by adults and in aerosol and nebulizer therapy. **Bristol Laboratories Inc., Dept. MH, Syracuse 1, N. Y. (Key No. 511)**

Tyroscape Solution

Tyroscape Solution is a new and effective product for the treatment of scabies. The three active ingredients include tyrothricin, benzyl benzoate and benzocaine in solution for local application. It is supplied in 4 fluid ounce bottles. **Sharp & Dohme, Inc., Dept. MH, Philadelphia 1, Pa. (Key No. 512)**

Benlyn Expectorant

Benlyn Expectorant has been developed for the treatment of cough due to colds and other congestive symptoms associated with colds. It is a palatable, raspberry flavored syrup combining approved medicinal agents which assist in liquefying and removing mucous secretions from the respiratory tract. It is supplied in 16 ounce and gallon bottles. **Parke, Davis & Co., Dept. MH, Detroit 3, Mich. (Key No. 513)**

Vitamin E Preparations

Abbott announces the development of two new vitamin E preparations. Both are indicated in the treatment of fibrosis, menopausal symptoms, vascular disease, habitual abortion and certain types of skin conditions.

Natopherol consists of distilled mixed tocopherols prepared from vegetable oils concentrated by molecular distillation resulting in a highly concentrated form for use by patients requiring vitamin E therapy. Syntopherol Acetate is a synthetic product producing all the known effects of vitamin E in experimental animals. The former is supplied in 25 and 50 mg. capsules in bottles of 100 and 500 and in 10 cc. vials in oil for intramuscular injection, the latter in 10 and 25 mg. tablets and in 10 cc. vials. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 514)**

Tersavin

Tersavin is a new drug for the treatment of acute and chronic sinus infections which combines the bactericidal action of penicillin with the vasoconstrictor effect of ephedrine. Available in stable tablets which dissolve readily and form a buffered, isotonic solution for local use, the product is supplied in packages of 8 foil-wrapped tablets together with a bottle graduated at 7.5 cc. in which the solution may be made. **Hoffmann-La Roche Inc., Dept. MH, Nutley 10, N.J. (Key No. 515)**

Depo-Penicillin

Depo-Penicillin is the Upjohn trade name for the improved repository form of procaine penicillin G. Pulverized so that the particle size is less than 5 micra, the crystalline procaine penicillin G is suspended in peanut oil gelled with 2 per cent aluminum monostearate, 300,000 units per cc. It is designed for slow absorption with effective blood levels maintained for prolonged periods, and the special processing makes for easy injection without plugging the needle. **The Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 516)**

Product Literature

- Ciba illustrations of anatomy and pathology which were prepared by Frank H. Netter, M.D., will soon be issued in book form containing 224 pages showing 191 of the anatomical charts printed in full color. The illustrations will be printed on 80 pound gloss enamel paper and the book will be bound in boards with blue buckram covering. The book will measure 9½ by 12½ inches and will contain all of the anatomical drawings, on all subjects of anatomy, which have been distributed by Ciba Pharmaceutical Products, Inc., Summit, N. J., up to January 1, 1948. The book will be sold by Ciba at a price to cover only the actual printing and binding costs and is entitled, "The Ciba Collection of Medical Illustrations." **(Key No. 517)**

- The new catalog issued by American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill., is a comprehensive, attractively prepared 604 page book bound in boards with the message "Plan With American" on the cover. The hundreds of items handled by this company, either as manufacturer or distributor, from solutions to furniture, are described and illustrated. The catalog material is completely indexed. **(Key No. 518)**

- A comprehensive catalog of "Edwards Electrical Signaling Communication and Protection" equipment for schools, colleges, hospitals and other buildings has recently been issued, in semi-loose-leaf form, by Edwards and Company Inc., Norwalk, Conn. The catalog is divided by marginal tabs clearly marked as to products and the complete index system makes it easy to find the desired data. Technical information, specifications, diagrammatic drawings and other illustrations on the complete line offered by this company are supplemented by detailed price lists at the end of each section. **(Key No. 519)**

- Auth Hospital Bulletin No. 170 is entitled "Typical Specifications and Typical Wiring Diagrams on Signaling, Communication and Protective Systems for Hospitals and Other Institutions." The book lives up to its title in every sense of the word, providing complete technical information, and is published by Auth Electric Co., Long Island City 1, N. Y. **(Key No. 520)**

- Various types of brass fittings, with size and price listings, two and three way shutoff valves and drain cocks and cross section views of fitting joints as well as views of the same joints disassembled are some of the items described and illustrated in Bulletin No. 352, "Handy Data on Brass Fittings," published by The Imperial Brass Mfg. Co., 1200 W. Harrison St., Chicago 7. **(Key No. 521)**

- A 12 page folder has been issued by Simmons Company, Merchandise Mart, Chicago 54, illustrating and explaining the operation of the "Deckert Multi-position Spring." Information on the new intermediate wing section and its advantages, essential body postures which can be achieved with the Deckert multi-position spring, bedpan positions for regular use and with horizontal patients and other details are described and fully illustrated together with carefully diagrammed operating instructions. **(Key No. 522)**

- "Years of Proven Service by Continentalair" is the title of the new 8 page brochure No. 128 recently published by Continental Hospital Service, Inc., 18636 Detroit Ave., Cleveland 7, Ohio. The Continentalair Iceless Oxygen Tent and other Continental hospital specialties are described and illustrated and all pertinent specifications and other technical details of interest to the administrator and the engineer are included. **(Key No. 523)**

- Full information on "Terraflex, the New Plastic Asbestos Floor Tile" is provided by Johns-Manville, 22 E. 40th St., New York 16, in an attractive, full color folder. **(Key No. 524)**

- The physiologic rôle and therapeutic usefulness of rennet are presented in a comprehensive, authoritative, 32 page book prepared in collaboration with nutritional and medical specialists and published by "Junket" Brand Foods, Division of Chr. Hansen's Laboratory, Inc., Little Falls, N. Y. Entitled "The Importance of Rennet in Infant and Adult Nutrition," the booklet will prove of interest to those concerned with hospital dietary problems. **(Key No. 525)**

Book Announcements

Paul B. Hoeber, Inc., 49 E. 33rd St., New York 16. Harris, "Modern Trends in Psychological Medicine," \$10. Fowler, "Hematology," 2nd Ed., \$8.50. Johlin, "Introduction to Physical Biochemistry," 2nd Ed., \$3.75. **(Key No. 526)**

The Macmillan Company, 60 Fifth Ave., New York 11. Edited by Gold, Barr, Cattell, DuBois, Tompsett, Modell, "Cornell Conferences on Therapy, Volume III," 337 pp., \$3.50. Shepard, "Textbook of Attendant or Practical Nursing," 506 pp., \$4.25. **(Key No. 527)**

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. DeGowin, Hardin and Abever, "Blood Transfusion," 587 pp., \$9. Mayo Clinic Diet Manual, 329 pp., \$4. Meloney, "Clinical Aspects and Treatment of Surgical Infections," 840 pp., \$12. Snyder, "Obstetric Analgesia and Anesthesia," 401 pp., \$6.50. **(Key No. 528)**

Suppliers' Plant News

American Tile and Rubber Co., Trenton, N. J., manufacturer of Amtico Rubber Tile, announces the opening of new showrooms at 281 Fifth Ave., New York, where extensive displays will show the complete line. (Key No. 529)

Columbia Mills, Inc., manufacturer of window shades and shade cloth, announces change of location from 225 Fifth Ave., New York 10, to 428 S. Warren St., Syracuse 2, N. Y. (Key No. 530)

Elgin Softener Corporation, Elgin, Ill., and **Illinois Water Treatment Co., Rockford, Ill.**, recently announced that they have joined forces. These two manufacturers of water conditioning material and equipment will consolidate manufacturing operations and research but each company will maintain its name identity and personnel. (Key No. 531)

Everest & Jennings, manufacturer of wheel chairs and walkers, announces removal of its headquarters from 7748 Santa Monica Blvd. to 761 N. Highland, Los Angeles 38, Calif. (Key No. 532)

Fedders-Quigan Corp., Buffalo 7, N. Y., announces the appointment of **Frank A. Mitchell** as Sales Manager of the Unit Air Conditioner Division, succeeding **E. A. Bonneville** who recently resigned. (Key No. 533)

The General Fireproofing Co., Youngstown 1, Ohio, manufacturer of metal furniture and equipment for offices and institutions, announces the opening of a new office and display room at 2121 Second Ave., Detroit 1, Mich., which will operate under the direction of **R. C. Scott**. (Key No. 534)

Kimble Glass, Division of Owens-Illinois Glass Co., Vineland, N. J., manufacturer of laboratory and hospital glassware, announces appointment of **E. B. Dennis Jr.** as General Sales Manager. (Key No. 535)

Wm. S. Merrell Company, Cincinnati 15, Ohio, manufacturer of pharmaceuticals, announces the promotion of **George W. Orr Jr.** to the post of General Sales Manager in charge of all sales operations and field personnel of the company. (Key No. 536)

Pittsburgh Corning Corp., manufacturer of structural glass blocks and cellular glass insulation, announces removal from Pittsburgh Plate Glass Bldg., Pittsburgh, to larger quarters at 307 Fourth Ave., Pittsburgh 22. (Key No. 537)

The Ray Proof Corp., manufacturer of x-ray and light-ray proofing equipment, has moved its offices from 330 E. 26th St. to 513 W. 54th St., New York 19. (Key No. 538)

Smith, Kline & French Laboratories, manufacturer of pharmaceuticals, announces removal of the research laboratories and manufacturing plant at Delaware Ave. and Poplar St. and the general offices at 429 Arch St. to a new building at 1530 Spring Garden St., Philadelphia 1, Pa. The new building, made entirely of steel, concrete, brick and tile, contains 395,000 square feet of floor area and has completely modern research laboratories and the newest in equipment. (Key No. 539)

Wright Manufacturing Co. is the new name of the manufacturing firm formerly known as Taylor Manufacturing Co. The company, manufacturer of Wright Rubber Tile, will continue its general sales headquarters under the new name at the present plant, 3056 W. Meinecke Ave., Milwaukee 10, Wis., but the main administration offices will be moved to the new \$2,000,000 Wright plant now under construction at Houston, Tex. A new general sales manager, **Bertram R. Scheff**, has been appointed by the president. (Key No. 540)

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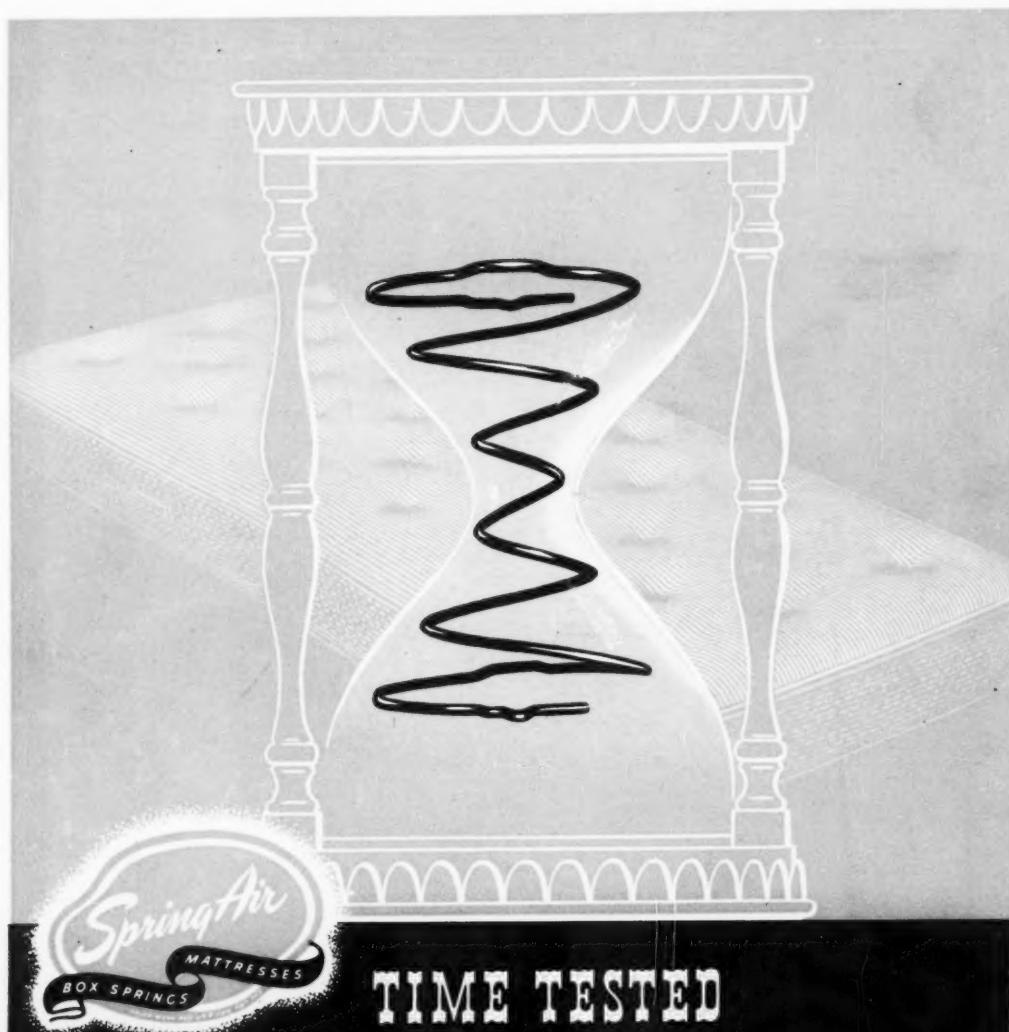
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